

DAVIS VISION

EYECARE REFRAMEDSM

Provider Change Request Form

RT REFERENCE #: _____

Provider Information

Today's Date	
Requested by	
Requestor's Phone Number	
Effective Date of Change	____ / ____ / ____ (MM, DD, YY)

Reason for Request

- Change current Office Phone/Fax Number including Area Code
- Change Network Status to No New Patients (NNP)
- Change current **Physical** Address
- Change current **Shipping** Address
- Change current **Billing** Address (**Please include W-9**)
- Change Tax ID Number (**Please include W-9**)
- Sell of Practice/Ownership change (**Please include W-9 and Bill of Sell**)

Yes No Does the Practice currently have the Davis Vision Exclusive Collection?

Current Office Information

Davis Vision Provider Number	
Office Name	
Current Address	
Current City, State Zip Code	
Current Phone Number	()
Current Fax Number	()
Current Tax ID Number	
Practitioner's Name	

New Office Information

New Address	
New City, State, Zip Code	
New Phone Number	
New Fax Number	
New Tax ID Number	

* Authorized Signature: _____ Date: _____

* Print Name: _____ *(Must sign and print name in full)

Submit completed requests to Network Operations by fax to 210-245-2369

03/24/2014; Rev. 01/04/2016