DAVIS VISION
EYECARE REFRAMED℠

Provider Termination Request Form

RT REFERENCE #: _____

☐ Terminate Office ☐ Terminate Practitioner

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

The Participating Provider Agreement may be terminated upon ninety (90) days prior, written notice. Providers shall continue to provide Covered Services to a Member who is receiving Covered Services on the effective termination date of this Agreement for a minimum transitional period of sixty (60) days from the date the Member is notified of the termination or pending termination, or until the Covered Services being rendered to the Member are completed.

Provider Information

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

Office and Practitioner Information

Davis Vision Provider Number	
Office Name	
Office Address	
City, State Zip Code	
Phone Number	( )
Fax Number	( )
Practitioner's Name (if multiple practitioner's per office, please indicate below)	
Practitioner's NPI	
Practitioner 2 Name	
Practitioner 2 NPI	

Reason for Termination

☐ Closed Practice
☐ Doctor Retired
☐ Doctor Deceased
☐ Doctor Left the Office/Group
☐ Sold Practice*
☐ Reimbursement Rates
☐ Lab Quality
☐ Lab Turn Around Time
☐ Unsatisfied with Communication
☐ Combined Practices*

* If Sold or Combined the Practice, please identify the associated Practice

Practice Name _____ Davis Vision Provider # (if applicable) _____

☐ Other – please explain _____

*** Authorized Signature** _____ **Date**_____

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

Submit completed request to Fax: 1-210-245-2369, Attn: Network Operations