DAVIS VISION
EYECARE REFRAMED℠

# Provider Termination Request Form

**RT REFERENCE #:** _______________

☐ Terminate Office ☐ Terminate Practitioner

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

## Provider Information

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

## Office and Practitioner Information

| | |
|---|---|
| Davis Vision Provider Number | |
| Office Name | |
| Street 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**

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