DAVIS VISION
EYECARE REFRAMED℠

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

____ Provider Name Change
____ Change current Office Phone/Fax Number including Area Code
____ Change Network Status to No New Patients (NNP)
____ Change current **Physica**l 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	
New National Provider Identifier (NPI)	

* Authorized Signature:_____ Date: _____

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

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