



**STATEMENT OF
CONTROLLED SUBSTANCE COVERAGE**

**COMPLETION OF THIS FORM IS REQUIRED IF PROVIDER
DOES NOT HAVE AN ACTIVE DEA CERTIFICATE**

Provider Name: _____

In order to be considered for participation on OptiCare medical panels, an applicant who does not have an active DEA certificate must provide an explanation as to why the applicant does not prescribe medications that require a DEA and the name of a consultant Optometrist/Ophthalmologist who prescribes controlled substances. The consultant must be available to provide appropriate patient care when the use of controlled substances is indicated.

Explanation of Why Applicant Does Not Prescribe Medications that Require a DEA:

Full Name of Provider with DEA: _____

Phone #: _____

DEA Certificate #: _____

I hereby certify that all the information provided on this form is true and current to the best of my knowledge.

I acknowledge that I have the responsibility to notify OptiCare Managed Vision if the arrangement between providers is in any way changed or terminated.

PREPARED BY (PRINT)

DATE

SIGNATURE

**FAX COMPLETED FORM TO (800) 980-4002
ATTN: CREDENTIALING**