



Panel Participation Request Form

Thank you for your interest in OptiCare Managed Vision/AECC/Total Vision Health Plan of Texas, Inc. (OMV/TVHP). The following information is needed to process your request for panel participation.

Please complete this form IN ITS ENTIRETY and return to Network Development at fax number (800) 980-4002. Incomplete forms will NOT be processed.

PROVIDER INFORMATION (ONE FORM PER PROVIDER):

PLEASE PRINT

Last Name:				<u>CAQH ID#:</u>	
First Name:					
Title/Suffix (please circle):		DO	MD	OD	OPT
Group Name:					
Office Address:					
Office City, State, Zip:					
County:					
Office Phone:		()	-		
Office Fax:		()	-		
Office Contact Name:					
SSN:		DEA:		Medicaid #:	
DOB:		UPIN:		Medicare #:	

For additional practice location(s), please attach a separate sheet with the address, phone, & fax.

DO YOU DISPENSE:

GLASSES: **Yes** **No**

CONTACTS: **Yes** **No**

DO YOU PRACTICE AT A RETAIL CHAIN?

WAL-MART	<input type="checkbox"/>	SEARS OPTICAL	<input type="checkbox"/>
JCPENNEY OPTICAL	<input type="checkbox"/>	TARGET OPTICAL	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	LENSCRAFTERS	<input type="checkbox"/>
DOC OPTICS	<input type="checkbox"/>	PEARLE VISION	<input type="checkbox"/>

CORRESPONDENCE ADDRESS (IF DIFFERENT FROM ABOVE):

Address:	
City, State, Zip:	

Please list below the plan(s) in which you are interested in participating on:

1.	
2.	
3.	
4.	

Upon receipt of your request for participation, a Provider Participation Agreement (PPA) & Fee Schedules will be mailed to your office for your review and execution.

SHOULD YOU HAVE ANY QUESTIONS, PLEASE CONTACT NETWORK DEVELOPMENT AT (800) 531-2818