

Provider Address Form

OptiCare Managed Vision

AECC Total Vision Health Plan of Texas

This form is for: Primary Office Location Branch Office Location

PRACTICE/GOUP LEGAL NAME (contracting entity):									
PRACTICE NAME (if d/b/a or other) for Directory Purposes:									
Tax ID #: _____ (each unique TID requires a separate W9 form)		Group/Billing NPI							
Office Address:						Ste:			
City:		St:		Zip:		County:			
Phone:	()	Fax:	()	Email:					
Services provided by this entity/location: ___ Routine Exam ___ Medical/Surgical ___ Glasses ___ Contact Lenses	OFFICE DETAILS			YES	NO	OFFICE HOURS			
	Is this loc. handicap accessible?					Sun:	to	Thu:	to
	Are you accepting new patients?					Mon:	to	Fri:	to
	Do you have age limitations to patient care?					Tues:	to	Sat:	to
	Is there a system for 24/7 on call availability?					Wed:	to		
	Are other languages spoken in this office (indicate)?					Languages:			
Is the contracted entity (at this location) affiliated with a separate optical: store/retailer/chain (provide name)?					Optical Name:				
BILLING OFFICE:	Please provide the applicable billing/correspondence office information for this entity if different than the practice location :								
Name:									
Address:						Ste:			
City /St /Zip:									
Contact Person:			Phone:		Fax:				

LIST THE DR(S). WHO PROVIDE SERVICES AT THIS LOCATION**	OD, MD, DO	MEDICARE #	MEDICAID #	CAQH ID OR DATE OF BIRTH***	INDIVIDUAL NPI #

** All participating doctors are required to complete a credentialing application (through CAQH or OptiCare); please let us know if we need to initiate credentialing for any current or new providers at this practice.

*** If provider does not currently have a credentialing profile on CAQH, please enter the provider's date of birth to allow OptiCare to create a CAQH account for the provider

TO LIST BRANCH OFFICES (AND SEPARATE LEGAL ENTITIES), PLEASE MAKE ADDITIONAL COPIES

**** INCOMPLETE AND INACCURATE FORMS MAY DELAY CLAIMS PROCESSING****