



# Provider Address Information

OptiCare Managed Vision  
AECC/Total Vision Health Plan of Texas, Inc.

Provider(s) effected by change: Name: \_\_\_\_\_ Title:  DO  MD  OD  OPT  
 Name: \_\_\_\_\_ Title:  DO  MD  OD  OPT  
 Name: \_\_\_\_\_ Title:  DO  MD  OD  OPT

Effective Date of New Office(s): \_\_\_\_\_ (Date provider will start seeing patients)

Are new locations Primary or Satellite? (circle one)

Is a location CLOSING? or is provider LEAVING practice? If yes, circle whether closing or leaving and enter old address information below

## Practice Address(es)

<b>1</b>	Practice Name	Address	Suite	City	State	County	
	Phone: ( ) - Fax: ( ) -					<b>Tax ID Number</b> <small>(A W-9 must be completed for each unique Tax ID)</small>	
	Do you dispense the following at this location? Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No						
	Texas Provider # (TPN): _____ <small>(A TPN is unique to each provider at each location, it is 7 digits with a 2 digit suffix)</small>						
	Is the Billing Address for this location the same as the Practice Address? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list Billing Address Number Applicable to Billing Addresses Listed Below:						
Office Hours Sun: - M: - T: - W: - Th: - F: - Sat: -							
<b>2</b>	Practice Name	Address	Suite	City	State	County	
	Phone: ( ) - Fax: ( ) -					<b>Tax ID Number</b> <small>(A W-9 must be completed for each unique Tax ID)</small>	
	Do you dispense the following at this location? Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No						
	Texas Provider # (TPN): _____ <small>(A TPN is unique to each provider at each location, it is 7 digits with a 2 digit suffix)</small>						
	Is the Billing Address for this location the same as the Practice Address? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list Billing Address Number Applicable to Billing Addresses Listed Below:						
Office Hours Sun: - M: - T: - W: - Th: - F: - Sat: -							
<b>3</b>	Practice Name	Address	Suite	City	State	County	
	Phone: ( ) - Fax: ( ) -					<b>Tax ID Number</b> <small>(A W-9 must be completed for each unique Tax ID)</small>	
	Do you dispense the following at this location? Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No						
	Texas Provider # (TPN): _____ <small>(A TPN is unique to each provider at each location, it is 7 digits with a 2 digit suffix)</small>						
	Is the Billing Address for this location the same as the Practice Address? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list Billing Address Number Applicable to Billing Addresses Listed Below:						
Office Hours Sun: - M: - T: - W: - Th: - F: - Sat: -							

ARE YOU ACCEPTING NEW PATIENTS?  Yes  No DO YOU PROVIDE 24HR./7 DAYS A WEEK COVERAGE FOR YOUR LOCATION(S)  Yes  No

## Billing Address(es)

Business Name	Address	Suite	City	ST	Zip
<b>1</b>					
<b>2</b>					
<b>3</b>					

PROVIDER SIGNATURE \_\_\_\_\_

\_\_\_\_\_  
National Provider ID

\_\_\_\_\_  
DATE

PRINTED NAME \_\_\_\_\_

\* If additional offices need to be listed, please make a copy and manually change numbering from 4-6, 7-9...