



Dear Eye Care Professional:

Thank you for taking advantage of OptiCare/TVHP's on-line Eye Health Manager. Your access is only a few short forms away!

Please complete and return the following documents to Network Management at fax number (800) 980-4002:

- Web Security Form
- W-9 Form
- Provider Address Information Form

OptiCare/TVHP requires the receipt of all the completed forms prior to issuing your secure Eye Health Manager login and password. Please contact Network Management at (800) 531-2818 should you have questions regarding this process or the enclosed amendment(s).

We look forward to working with you and your staff while providing quality eye care services to Members in your area!

Sincerely,

Network Management  
Provider Affairs Division



## Return Fax Sheet

**To:** Network Management

**From:** \_\_\_\_\_

**From:** (800) 980-4002  
cover

**Pages:** \_\_\_\_\_, including

**Phone:** (800) 531-2818

**RE:** On-line *Eye Health Manager* Request

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Please process my request for secure access to OptiCare/TVHP's on-line *Eye Health Manager*.

As instructed, I have completed the below documents and am returning them to you begin this process.

Required Documents:

- Web Security Form
- W-9 Form
- Provider Address Information Form

Should you have any additional questions or need additional information to complete this process, please contact \_\_\_\_\_ at (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_.



Provider Maintenance
OptiCare Managed Vision
P.O. Box 7548
Rocky Mount, NC 27804

Security Letter
Fax (800) 980-4002

Dear Provider Maintenance,

Please accept this letter as a request to set up an account to access the secure areas of the OptiCare Managed Vision (OptiCare) web site at www.opticare-ehn.com. I understand this access is only available to providers currently contracted with OptiCare.

I hereby attest that the information given in this letter of application is accurate and complete. By signing this document I fully understand and agree to the following terms and conditions:

- 1. It is my responsibility to ensure that the security code provided to me by OptiCare to gain access to confidential information maintained on OptiCare's web site will be maintained in confidence and only used by me and/or by my employed staff.
2. In the event my provider security code is compromised in any way, I will immediately notify OptiCare's Provider Relations Department to report such incident and to request a new security code.
3. I acknowledge that OptiCare's provider security access code can only be communicated in writing and sent by first-class mail to my designated primary office location.
4. My provider security access code to OptiCare's website can be terminated at any time without notice at the sole discretion of OptiCare.
5. Unauthorized use of my provider security code may be grounds for provider termination from OptiCare.
6. All information on this form will be verified and must match the previous information on the provider's credentialing application that OptiCare has on file.
7. If any provider that shares the same tax ID number or any staff member in my office that accesses the web site terminates employment, it is my responsibility to notify OptiCare's Provider Relations Department of this termination so that a new security code can be issued for the office.
8. Should my contract terminate with OptiCare, I acknowledge that my access to the web site will be terminated the date my contract termination becomes effective.

Doctor's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Full Name: \_\_\_\_\_

(Please Print)

Office Address: \_\_\_\_\_

Please list additional locations on a separate sheet and attach.

Tax ID No.: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Office Phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_

Please be sure that all providers in your practice have signed and completed a form before returning this letter to the above address.

\*\*\*\*\*OMV/TVHP USE ONLY\*\*\*\*\*

OMV/TVHP Initials \_\_\_\_\_
OMV/TVHP Date \_\_\_\_\_ User ID \_\_\_\_\_ Password \_\_\_\_\_



Provider Name: \_\_\_\_\_ Title:  DO  MD  OD  OPT

Last First MI

INDIVIDUAL (TYPE I) NATIONAL PROVIDER IDENTIFIER (NPI) \_\_\_\_\_

ORGANIZATIONAL/BILLING (TYPE II) NPI (if applicable) \_\_\_\_\_

<b>Primary Location:</b>	
Practice Name d/b/a (or directory listing) _____	
Address _____ Suite _____	
City _____ ST _____ Zip _____ County _____	
Phone: (    )    -    Fax: (    )    -	
Routine Exam Services <input type="checkbox"/> Yes <input type="checkbox"/> No                      Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Medical/Surgical Services <input type="checkbox"/> Yes <input type="checkbox"/> No                      Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Is this location Handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you provide 24hr / 7 days a week coverage for this location? <input type="checkbox"/> Yes <input type="checkbox"/> No ***MEDICAID LOCATION # (for TX, PA, GA & IN providers only) _____ Is this location a Retail Chain? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>IF YES INDICATE RETAIL CHAIN</b> _____	
Office Hours Sun:    -    M:    -    T:    -    W:    -    Th:    -    F:    -    Sat:    -	
<b>Billing:</b>	Tax ID Number <small>(A W-9 must be completed for each unique Tax ID)</small>
Business Name _____	_____
Address _____	_____
City _____ ST _____ Zip _____	_____

<b>Additional Location:</b>	
Practice Name d/b/a (or directory listing) _____	
Address _____ Suite _____	
City _____ ST _____ Zip _____ County _____	
Phone: (    )    -    Fax: (    )    -	
Routine Exam Services <input type="checkbox"/> Yes <input type="checkbox"/> No                      Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Medical/Surgical Services <input type="checkbox"/> Yes <input type="checkbox"/> No                      Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Is this location Handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you provide 24hr / 7 days a week coverage for this location? <input type="checkbox"/> Yes <input type="checkbox"/> No ***MEDICAID LOCATION # (for TX, PA, GA & IN providers only) _____ Is this location a Retail Chain? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>IF YES INDICATE RETAIL CHAIN</b> _____	
Office Hours Sun:    -    M:    -    T:    -    W:    -    Th:    -    F:    -    Sat:    -	
<b>Billing:</b>	Tax ID Number <small>(A W-9 must be completed for each unique Tax ID)</small>
<input type="checkbox"/> Same As Practice Location <input type="checkbox"/> Other (indicate below)	_____
Business Name _____	_____
Address _____	_____
City _____ ST _____ Zip _____	_____

**Additional Office Locations**

<b>Additional Location:</b> Practice Name d/b/a (or directory listing) _____ Address _____ Suite _____ City _____ ST _____ Zip _____ County _____ Phone: (     )     -                      Fax: (     )     -	
Routine Exam Services <input type="checkbox"/> Yes <input type="checkbox"/> No                      Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Medical/Surgical Services <input type="checkbox"/> Yes <input type="checkbox"/> No                      Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Is this location Handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you provide 24hr / 7 days a week coverage for this location? <input type="checkbox"/> Yes <input type="checkbox"/> No ***MEDICAID LOCATION # (for TX, PA, GA & IN providers only) _____ Is this location a Retail Chain? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>IF YES INDICATE RETAIL CHAIN</b> _____	
Office Hours Sun:   -   M:   -   T:   -   W:   -   Th:   -   F:   -   Sat:   -	
<b>Billing:</b> <input type="checkbox"/> <b>Same As Practice Location</b> <input type="checkbox"/> <b>Other (indicate below)</b> Business Name _____ Address _____ City _____ ST _____ Zip _____	Tax ID Number <small>(A W-9 must be completed for each unique Tax ID)</small> _____

  

<b>Additional Location:</b> Practice Name d/b/a (or directory listing) _____ Address _____ Suite _____ City _____ ST _____ Zip _____ County _____ Phone: (     )     -                      Fax: (     )     -	
Routine Exam Services <input type="checkbox"/> Yes <input type="checkbox"/> No                      Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Medical/Surgical Services <input type="checkbox"/> Yes <input type="checkbox"/> No                      Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Is this location Handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you provide 24hr / 7 days a week coverage for this location? <input type="checkbox"/> Yes <input type="checkbox"/> No ***MEDICAID LOCATION # (for TX, PA, GA & IN providers only) _____ Is this location a Retail Chain? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>IF YES INDICATE RETAIL CHAIN</b> _____	
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<b>Billing:</b> <input type="checkbox"/> <b>Same As Practice Location</b> <input type="checkbox"/> <b>Other (indicate below)</b> Business Name _____ Address _____ City _____ ST _____ Zip _____	Tax ID Number <small>(A W-9 must be completed for each unique Tax ID)</small> _____

**\* IF ADDITIONAL OFFICES NEED TO BE LISTED, PLEASE MAKE A COPY**