



Network Development
OptiCare Managed Vision
P.O. Box 7548
Rocky Mount, NC 27804

Security Letter
Fax (800) 980-4002

Dear Network Development,

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 _____