



Information Request Form

NOTE: This is not an application. Providers are not credentialed using this form.

If you would like information about becoming an Advantica EyeCare network provider, please complete this form and return it to:

By mail: Advantica EyeCare
3290 Pine Orchard Lane, Suite D
Ellicott City, MD 21042
Attn: Network Management

By fax: (410) 465-3061, **Attn: Network Management**

Please be sure to complete all information. Incomplete forms can not be processed.

Advantica EyeCare assesses all requests based on network needs in specific geographic locations. Based on network needs in your area, Advantica EyeCare may forward an application package to your practice. Please be aware that returning a completed application is not a guarantee that your practice will be added to Advantica EyeCare's provider network. In the event that the network is closed in your area at the time of your request, your Provider Application Request Form will remain on file. **ALLOW 30 DAYS FOR A RESPONSE.**

Contact Person for applications and credentialing: _____

How many providers are in the practice?: _____

Do you have an optical on site? Yes _____ No _____

Names of all providers in the practice (attach separate sheet if necessary):

1) Name: _____ **O.D. M.D. (circle one)**

CAQH #: _____ Medicare #: _____ Medicaid #: _____ NPI #: _____

2) Name: _____ **O.D. M.D. (circle one)**

CAQH #: _____ Medicare #: _____ Medicaid #: _____ NPI #: _____

3) Name: _____ **O.D. M.D. (circle one)**

CAQH #: _____ Medicare #: _____ Medicaid #: _____ NPI #: _____

4) Name: _____ **O.D. M.D. (circle one)**

CAQH #: _____ Medicare #: _____ Medicaid #: _____ NPI #: _____

Practice name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Phone: _____ **Fax:** _____

Email: _____ **Tax ID Number:** _____