## Panel Participation Request Form

Thank you for your interest in becoming an Envolve Vision provider. The following information is needed to process your request for panel participation.

Please complete this form **in its entirety** and return to our Network Management Department. Incomplete forms will **not** be processed.

**Provider Information (one form per provider):**
**Please Print**

Last Name: _____ First Name: _____ Title/Suffix (DO, MD, OD, OPT):_____

TIN: _____ DOB: _____ NPI: _____ CAQH ID: _____

Medicaid #:_____ Medicare #:_____

Group Name: _____

Office Address: _____

Office City: _____ Office State: _____ Office Zip + 4: _____County: _____

Office Phone: _____ Office Fax: _____

Office Contact and Email Address: _____

*For additional practice location(s), please attach a separate sheet with the address, phone, & fax.*

Do you dispense: **Glasses** ☐ Yes ☐ No **Contacts** ☐ Yes ☐ No

Do you practice at a retail chain: ☐ **Wal-Mart** ☐ **JCPenney Optical** ☐ **Sears Optical** ☐ **Target Optical**
☐ **Lenscrafters** ☐ **Pearle Vision** ☐ **DOC Optics** ☐ **Other**

Correspondence Address (If different from above):

Street Address: _____

City: _____ State: _____ Zip + 4: _____

**Please list below the plan(s) in which you are interested in participating on:**

**1.**_____

**2.**_____

**3.**_____

**4.**_____

**Fax completed form to (866) 614-4951 or email to visionnetworkmanagement@envolvehealth.com**

Upon receipt of your request for participation, a Provider Participation Agreement (PPA) & Fee Schedules will be mailed to your office for your review and execution.

Should you have any questions, please contact Network Management at (800) 531-2818, option 4