ADDITIONAL LOCATION FORM Effective Date: _____

Provider Name:	Provider Number: *(Leave blank)*

NEW LOCATION INFORMATION:

Street Address:		
City:		
State:	Zip:	County:
Phone: ( ) -	Fax: ( ) -	

Office Hours: M_____ T_____ W_____ TH_____ F_____ SAT_____ SUN_____
Languages spoken by doctor and/or staff at this location: _____

A fee of $250.00 is required for each additional dispensing office. The exception is when there is already a participating provider listed as dispensing at the above-mentioned address. Make checks payable to the Eye Care Network.

Check all that applies: Eye Exams: ☐ Frames & Lens ☐ Contact Lens ☐
For Administrative Use Only: Check # _____ Check Amount $_____ Fee Paid By_____ Provider # _____

Please attach a W-9 tax form with this request.

Tax ID Number:	Make Checks Payable to: Eye Care Network
Effective Date of Tax ID Number:	Check One: □Sole Proprietor □Corporation □Partnership/Other

Mail to: The Eye Care Network, Attention: Provider Relations, PO Box 25209, Santa Ana, CA 92799

Or

Fax to: (714) 824-8816, Attention: Provider Relations Department