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| --- | --- |
| **Provider Information:** [ ]  *Please check if you are a new provider.* | Date \* required       |
| Vision Care Provider \* required      | ProviderOne Number \* required      |
| Contact (Name) \* required      | Phone \* required      |
| Address      | Fax      |
| City      | State      | Zip      | [ ]  *Please check if there has been an address change.* |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Frame Name** | **Frame Color** | **Eye Size** | **QTY** |  |  | **Frame Name** | **Frame Color** | **Eye Size** | **QTY** |
| 1. |       |       |       |       |  | 13. |       |       |       |       |
| 2. |       |       |       |       |  | 14. |       |       |       |       |
| 3. |       |       |       |       |  | 15. |       |       |       |       |
| 4. |       |       |       |       |  | 16. |       |       |       |       |
| 5. |       |       |       |       |  | 17. |       |       |       |       |
| 6. |       |       |       |       |  | 18. |       |       |       |       |
| 7. |       |       |       |       |  | 19. |       |       |       |       |
| 8. |       |       |       |       |  | 20. |       |       |       |       |
| 9. |       |       |       |       |  | 21. |       |       |       |       |
| 10. |       |       |       |       |  | 22. |       |       |       |       |
| 11. |       |       |       |       |  | 23. |       |       |       |       |
| 12. |       |       |       |       |  | 24. |       |       |       |       |

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| **Please return this form via fax or as an email attachment to:** | FAX: 1.888.606.7789 |
|  | Email: *CIOpticalCustomerCare@doc.wa.gov* |
| **Or mail to:** | CI Optical Customer CarePO Box 1959Airway Heights, WA 99001-1959 |  |  |