|  |  |  |  |
| --- | --- | --- | --- |
| **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.* |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **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. |  |  |  |  |

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