

NEW DOCTOR REQUEST FORM

Please fill out the requested information below and send to customerservice@classicoptical.com or fax it to us at 888-522-2022.

Date:	
Name of Doctor:	
Name of Practice:	
Is your practice associated with another entity?	If your practice is associated with another entity (such as a partnership or private equity group), please provide the name of the entity:
Address:	
Phone Number:	
Fax Number:	
Email Address:	
Doctor's individual NPI and Taxonomy Number	
Medicaid ID Number (if applicable):	
Tax Exempt? <i>(If YES, please provide exempt form)</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO
Expected number of frame-only orders/month	
Accounts Payable Contact Person (name/phone #/email):	
Preferred Method of Payment	<input type="checkbox"/> Check <input type="checkbox"/> ACH <input type="checkbox"/> Credit Card <input type="checkbox"/> AutoPay
Name of a Contact Person:	
Doctor's or Office Manager's Signature:	

