RHODE ISLAND
PHYSICIANS CORPORATION
PRIMARY CARE

Rhode Island Primary Care Physicians Corporation Eye Care Provider Application

Please complete the following application and mail back, along with all required supporting documents and membership fee for $750.00 per provider to:
RIPCPC
c/o Eye Care membership
1150 New London Ave., Suite 20
Cranston, RI 02920

Provider Name:_____

Office/Practice Name_____

Office/Practice address_____

_____

Additional office locations:_____

_____

Phone_____Fax_____

Additional phone/Back line_____

Provider Email_____

Office/Practice email (if different) _____

Do you wish to list an email in the online referral directory? _____

If Yes, which email?_____

Office Manager/Administrator_____

Office Manger/Administrator email_____

Please list all other providers in the office/pratice:_____

_____

RHODE ISLAND
PHYSICIANS CORPORATION
PRIMARY CARE

Office Hours:

Monday_____ Tuesday_____

Wednesday_____ Thursday_____

Friday_____ Saturday_____

Sunday_____

Please select services offered:

__**General optometry** ___**General ophthalmology**

__Ophthalmology: Retina medical

__Ophthalmology: Retina surgical

__Ophthalmology: Glaucoma surgery

__Ophthalmology: Cataract surgery

__Ophthalmology: Lasik
(but most evaluations will go to optometry first)

__Ophthalmology: Strabismus surgery

__Ophthalmology: Cornea (non Lasik) surgery

__Ophthalmology: Oculoplastic surgery

Languages Spoken:

_____English
_____Greek
_____Vietnamese
_____Portuguese

_____Italian
_____Spanish
_____Creole
_____Arabic
_____Mong

Please select populations served:

Pediatric_____
Senior Care_____
Family Optometric_____

Children_____
Adults_____
Seniors_____

Please select insurances accepted:

Blue Cross Blue Shield___

United Health Care___

Tufts Health Pla___

Harvard Pilgrim___

Aetna___

Neighborhood Health Plan of RI___

Medicare___

Medcaid of RI___

RiteCare___

London Health___

Cigna___

Tricare___

Other___

RHODE ISLAND
PHYSICIANS CORPORATION
PRIMARY CARE

*Full unrestricted license to practice optometry / ophthalmology in RI
Lic #_____ exp date_____

*Federal Controlled Substance # (DEA) _____exp date_____

Board Certification or Board Eligible (Eligibility expires_____) Board:_____

NPI Number_____

Provider date of birth: _____ Social Security number _____

Tax-ID (Please include copy of W-9) _____

Professional School Name_____

Location_____

Dates attended:_____Grad date _____

Hospital Privileges (if applicable): Please list all hospitals: _____
_____

*Professional Liability Insurance Company(min $1M/3M) _____

Malpractice Claim History (please provide brief explanation of each incident on seperate sheet):

_____

Electronic Medical Record Vendor: _____

E-prescribing Vendor:_____

*Please provide a copy of (1) State license, (2) DEA certificate (3) Professional liability policy face sheet.

EMR is not required for acceptance BUT ability to communicate electronically MAY BE mandatory (example: Direct). Faxing may be acceptable as well.

EMR is mandatory within 2 years of the date of acceptance. Those members who do not have EMR within 2 years will be terminated from the group.

ALL applicants must have full unrestricted license and DEA
If not applicable at time of application, a 9 month grace period will be allowed.
Those not providing evidence of full licensure/DEA within 9 months of date of application will be terminated.

Board Certification for both optometry and ophthalmology is not a requirement at this time but may be a mandatory criteria for membership in the future.