Please describe your, your clinic or your agency's method for maintaining confidentiality (attach policy and/or forms):

____

Please describe your, your clinic or your agency's method for handling client/patient grievance (attach policy and/or forms):

Have you or your organization ever had your license, accreditation, or certifications suspended?

☐ YES ☐ NO

If yes, please provide details:

Have you, any physician or staff ever had your license, accreditation, or certifications suspended?

☐ YES ☐ NO

If yes, please provide the name of the person and the details:

Have you or your organization ever had your license, accreditation, or certifications revoked?

☐ YES ☐ NO

If yes, please provide details:

Have you, any physician or your organization ever had your license, accreditation, or certifications revoked? ☐ YES ☐ NO

If yes, please provide the name of the person and the details:

How do patients cover the costs of client services? (check all that apply)

☐ Free ☐ TennCare ☐ Medicare ☐ Private Insurance (PPO) ☐ Private Insurance (HMO)

☐ Other (specify) ____

Please indicate your current hours and locations of operation: (check all that apply)

Monday through Friday ☐ 8am-5pm ☐ 5pm-10pm ☐ After 10pm

Saturday and/or Sunday ☐ 8am-5pm ☐ 5pm-10pm ☐ After 10pm

List location(s) addresses (Street, City and Zip)

____

____

____

____

Is your clinic/agency handicapped accessible? ☐ YES ☐ NO

Please specify the region(s) within Middle Tennessee in which you provide HIV/AIDS care-related services:

☐ Nashville/Davidson county ☐ Mid-Cumberland ☐ South Central ☐ Upper Cumberland

☐ Memphis/Shelby ☐ West ☐ South West ☐ East ☐ Southeast ☐ Northeast

If my application is approved, I understand that my agency or I must charge according to The Ryan White Services Fee Schedule. The fees listed on the Ryan Services Fee Schedule is the maximum amount allowed for reimbursement. The patient may not be charged for any amount regardless of the stated fees. I understand that the Fee Schedule is for HIV/AIDS patients who have no insurance, reside in Tennessee, and are treated on an outpatient basis only. Under no circumstances can payment be made for an IN-HOSPITAL stay or confinement to an institution. All services must be provided to treat only HIV- specific problems or secondary problems directed related to OR expected to negatively impact the patient's HIV disease.

I agree to the following conditions listed above.

Name: ______________________________ Signature: ______________________________

Title: ______________________________ Date: ______________________________

Please submit via email to rickey.thomas@uwmn.org or
Eye Care Initiative, United Way Metropolitan Nashville,
Mr. Rickey Thomas, 250 Venture Circle, Nashville, TN 37228

Eye Care Initiative Billing Form
United Way Metropolitan Nashville
Ryan White Part B Program
Ph: 615-780-2474
rickey.thomas@uwmn.org

Provider Application

Provider Information

Name: ______________________________ Email: ______________________________
Last Name, First Name, Middle Initial, Suffix (Jr., II, II)

Eye Care Practice: ______________________________ Telephone: ______________________________
(Include Area Code)

Practice Address: ______________________________ Fax: ______________________________
No. and Street Suite. Number

____
City State Zip Code

Mailing Address: ______________________________
No. and Street Suite. Number

____
City State Zip Code

Tax ID Number: ______________________________

Please indicate the services for which you, your clinic, or agency seek to provide on the Ryan White Fee for Service form.
NOTE: These are the *only* approved services. Please check the service(s).

√	Code	Description	Fee
	92004	Comprehensive Exam	$95.00
	V2100	Spectacle Frames Fitted with Single Lens	$100.00
	V2200	Spectacle Frames fitted with Bifocal Lens	$125.00

How many years has your organization provided these services?

☐Less than 1 ☐ 1 to 4 ☐ 5 to 9 ☐10 or more

Please list your, your agency's or organization's license(s), accreditation(s), or certification(s) relevant to the services that you are applying to provide:

License/Certification Number Expiration Date

____
____
____
____

Please list your, your agency's or organization's license(s), accreditation(s), or certification(s) relevant to the services that you are applying to provide: ______________________________

____
____