



Provider Nomination Form

If you wish to nominate a particular Optometrist, Ophthalmologist or Optician for participation on the EyeMed Vision Care provider network, please complete the following information and return the completed form to:

Mail To:
EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040
Attn: Network Development

Fax To:
513-492-6191

E-mail To:
hrufft@eyemedvisioncare.com

Group Name: _____

Your Name: _____ **Date:** _____

Name of Provider: _____

Please circle one of the following: **Ophthalmologist (M.D.)** **Optometrist (O.D.)** **Optician/Dispensary (Opt.)**

Street: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: (____) _____ - _____ **Fax:** (____) _____ - _____

Comments: _____

Please be aware that submission of a Provider Nomination is not a guarantee that the provider/facility will become an EyeMed network provider. Please check with your provider prior to receiving services.

<i>For EyeMed Vision Care Use</i>
Date Received: _____
By: _____