

Provider Nomination Form

If you wish to nominate a particular optometrist, ophthalmologist or optician for participation in the EyeMed Vision Care network, please complete the following information and return the form via:

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 form is not a guarantee that the provider/facility will become an EyeMed network provider. Please check with your provider prior to receiving services.

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