Provider Nomination Form

Dear EyeMed Member:
If you wish to nominate a particular Optometrist, Ophthalmologist or Optician for participation in the EyeMed Vision Care provider network, please ask your Eye Care Professional to complete the following information and return the completed form to EyeMed.

Your Name: _____

Group/Employer Name: _____

Dear Eye Care Professional,
The EyeMed Vision Care member listed above is requesting your participation in the EyeMed Vision Care Network. Please complete the information below, sign and return to EyeMed Vision Care. You will hear from EyeMed within 45 (forty five) days of receipt of this request.

Name of Provider: _____ ☐ **M.D.** ☐ **O.D.** ☐ **Optician**

Name of Facility: _____

Street: _____

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

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

Eye Care Professional Signature: _____

Please be aware that submission of a Provider Nomination is not a guarantee that the provider/facility will become an EyeMed network provider.

Mail or fax completed form to:
EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040
Fax: (513) 492-6191
Attn: Network Development

For EyeMed Vision Care Use only: Date Rcv'd:_____By:_____