



Provider Nomination Form

If you wish to nominate a particular optometrists, ophthalmologists or optician for participation on the EyeMed Network, please complete the following form and return your nomination to:

EyeMed Vision Care FAX: 513-765-3028
Attn: Provider Relations E-mail: hrufft@eyemedvisioncare.com
4000 Luxottica Place
Mason, OH 45040

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: _____

This is not a guarantee that the above provider/facility will be eligible to become an EyeMed provider. Please check with your provider prior to receiving services.

EyeMed Customer Service is available seven days a week, including evenings. The Customer Care Center is available at 866-798-9189 Monday through Saturday 8:00 a.m. to 11:00 p.m. EST and Sunday from 11:00 a.m. to 8:00 p.m. EST.

Your time and assistance in completing this form is appreciated and will help us to provide you with the provider access you deserve. Thank you for submitting this nomination.

Date Received: _____
By: _____