



Provider Nomination Form

If you want to nominate a particular optometrist, ophthalmologist, or optician for participation in 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:** _____

Provider Name: _____

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 before 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 provide you with the provider access you deserve. Thank you for submitting this nomination.

Date Received: _____
By: _____