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:	Fax To:	E-mail To:
EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 Attn: Network Development	513-492-6191	mellis1@eyemed.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.

For EyeMed Vision Care Use
Date Received: _____
By: _____

Revised 07.19.18