



## Provider Nomination Form New York State Vision Plan

If you wish to nominate a particular Optometrists, Ophthalmologists or Optician for participation on the EyeMed Vision Care provider network, please complete the following information and return the completed form to:

Mail To:  
EyeMed Vision Care  
4000 Luxottica Place  
Mason, OH 45040  
Attn: Network Development

Fax To:  
513-765-3028

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 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: \_\_\_\_\_