

See yourself healthy.

PROVIDER NOMINATION FORM

Please complete this form if you wish to recommend a provider for possible contracting into the Superior Vision Plan Preferred Provider Panel. You may either mail or fax your completed nomination form to:

Superior Vision Services, Inc. Provider Relations 11101 White Rock Rd Rancho Cordova, CA 95670

Fax: 916.852.2380

Your Name:		Date:
Company:		
Name of Provider:		
☐ Ophthalmologist (MD)	☐ Optometrist (OD)	☐ Optician or Optical Store
Street Address:		
City:	State:	Zip Code:
Email address:		
Telephone: ()	Fax: ()

If you have any questions regarding a provider nomination, please call Customer Service at 800.507.3800.

Please note that every effort will be made to consider your nomination. However, geographical network space, provider's response, or Superior Vision's qualifying guidelines may restrict provider participation.

SuperiorVision.com