



## 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/Network Development  
11050 Olson Drive, Ste. 102  
Rancho Cordova, CA 95670  
Fax: (916) 852-2380

Your Name: _____	Date: _____	
Company: _____		
Name of Provider: _____		
<input type="checkbox"/> Ophthalmologist (MD)	<input type="checkbox"/> Optometrist (OD)	<input type="checkbox"/> Optician or Optical Store
Street: _____		
City: _____	State: _____	Zip Code: _____
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 and Superior Vision's qualifying guidelines may restrict provider participation.