SUPERIOR VISION

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