



**Superior Vision**<sup>®</sup>  
*Our Members. Our Mission.*

## 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  
11101 White Rock Rd., Suite 150  
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 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.