



Provider Nomination Form

If you wish to nominate a particular optometrists, ophthalmologists or optician for participation in the TruAssure / EyeMed Vision Care network, please complete the following form and return your nomination to:

EyeMed Vision Care
Attn: Provider Relations
4000 Luxottica Place
Mason, OH 45040

FAX: 513-492-4999
E-mail: EyeMedProviderRelations@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: _____

This is not a guarantee that the above provider/facility will be eligible to become a TruAssure / EyeMed Vision Care provider. Please check with your provider prior to receiving services.

Customer Service for your vision plan is available seven days a week, including evenings. The Customer Care Center is available at 866-723-0513 Monday through Saturday 7:00 a.m. to 10:00 p.m. CST and Sunday from 10:00 a.m. to 7:00 p.m. CST.

Your time and assistance in completing this form is appreciated and will help us to provide you with the provider access you deserve. Thank you for submitting this nomination.

Date Received: _____

By: _____