Superior Vision®

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: _____

☐ 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.