



### **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 for the National Network. You may either mail or fax your completed nomination form to:

State of Texas Vision  
c/o Superior Vision, Administrators  
Attn: Provider Relations  
P.O. Box 967  
Rancho Cordova, CA 95741  
Fax: (916) 852-2380

Your Name: _____		Date: _____
Plan Name: <u>State of Texas Vision</u>		
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 (877) 396-4128.

The credentialing process can take up to 60 days and 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. Please verify your eye care provider's non-network participation prior to obtaining services. Non-network providers may require payment in full at the time of service and you will need to submit a claim for reimbursement at non-network rates.