UnitedHealthcare®

Provider Nomination Form*

If you wish to nominate a particular ophthalmologist, optometrist or optician as a Vision Network Provider, please complete this form and email it to **visionnominations@uhc.com** or fax to 844-558-8451.

Group Name: _____

Your Name: _____ Date: _____

Name of Provider: _____

Please check one of the following:

☐ **Ophthalmologist** ☐ **Optometrist** ☐ **Optician** ☐ **Lasik Surgeon**

Street: _____

City: _____ State: _____ Zip: _____

Telephone: _____

UnitedHealthcare will make every attempt to contact nominated providers. Please allow 30 to 60 days from the time this form is received for the potential provider to be contacted.

It is our goal at to provide you and your eligible dependents with the highest-quality vision care plan available. Your time and assistance in completing this form is appreciated and will help us to provide you with extensive provider access.

*Please note that nominating a provider does not necessarily guarantee that the provider will be a participant in our Provider Network. ***Our Lasik partner owns and operates their network of providers. Acceptance into our Vision Provider Network and our Lasik partner's network are independent of each other.*** A number of factors can affect a provider's participation. Some factors include but are not limited to geographic distribution of the existing network and population demographics.

Thank you for submitting this Provider Nomination Form.