

Provider Nomination Form*

If you wish to nominate a particular ophthalmologist, optometrist or optician as a UnitedHealthcare Vision Care Provider, please complete this form and mail or fax it to:

UnitedHealthcare Vision

Attn: Network Development

Liberty 6, Suite 200

6220 Old Dobbin Lane

Columbia, MD 21045

Fax: 443-896-0515

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 Vision will make every attempt to contact nominated providers. Please allow 30 to 60 days from the time that UnitedHealthCare Vision receives this form for the potential provider to be contacted.

It is our goal at UnitedHealthcare Vision 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 of UnitedHealthcare Vision's network. ***LCA-Vision owns and operates the Lasik panel. Acceptance into UnitedHealthcare Vision's network and LCA'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.