



## VisionChoice® Provider Nomination Form

Please complete this form if you wish to recommend a provider for participation in the VisionChoice® program. You may mail, e-mail or fax your completed nomination form to:

**Southland Benefit Solutions**  
Vision Provider Relations/Network Development  
Attn: Glynda Simpson  
1812 University Blvd, Suite One  
Tuscaloosa, Alabama 35401  
Fax: (205) 343-1239  
E-mail: [gsimpson@southlandbenefit.com](mailto:gsimpson@southlandbenefit.com)

**Your Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Your Company:** \_\_\_\_\_

**Name of Provider:** \_\_\_\_\_

Ophthalmologist (MD)     Optometrist (OD)     Optician or Optical Store

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

Please note that every effort will be made to consider your nomination. However, geographical location and VisionChoice® 's qualifying guidelines may restrict provider participation.