Heritage Vision Plans
Doctor Nomination Form

I would like to formally nominate my doctor or vision provider for inclusion in the Heritage Vision Plans Network. I understand that Heritage retains final authority for approving membership in its provider network. I also understand that Heritage may inform the doctor of my nomination.

MEMBER'S INFORMATION:

Date: ______________________________

Member Name: ______________________________

Employer/Group Name: ______________________________

Phone: ______________________________

Email: ______________________________

PROVIDER / DOCTOR INFO:

Practice Name: ______________________________

Doctor(s) Name: ______________________________

Address: ______________________________

Address 2: ______________________________

City, State, Zip: ______________________________

Phone: ______________________________

Email: ______________________________

Please Submit Completed form to:
(Mail, Fax, or e-mail)

Heritage Vision Plans, Inc.
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Toll Free: 800.252.2053
Fax: 313.863.1189
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