VS EYEWEAR

SUBMIT THIS FORM DIRECTLY TO
YOUR INSURANCE PROVIDER

DIRECT REIMBURSEMENT CLAIM FORM

MEMBER INFORMATION

MEMBER ID #: _____
GROUP #: _____
MEMBER NAME: _____
DATE OF BIRTH: _____

MAILING ADDRESS: _____
CITY: _____
STATE: _____
ZIP: _____
PHONE: _____

PATIENT INFORMATION

RELATIONSHIP TO MEMBER:

Self *Spouse* *Child* *Other*

PATIENT NAME: _____
DATE OF BIRTH: _____

MAILING ADDRESS: _____
CITY: _____
STATE: _____
ZIP: _____
PHONE: _____

PURCHASE INFORMATION

PROVIDER: VS Eyewear
ADDRESS: 26 Broadway
CITY: Bangor
STATE: PA
ZIP: 18013
PHONE: 1-484-546-0029

ORDER: _____
PURCHASE DATE: _____
ITEM(S) PURCHASED: _____
FRAMES AMOUNT: _____
LENS AMOUNT: _____
LENS TYPE (if applicable):

Single Vision *Progressive* *Bifocal* *Other*

MEMBER SIGNATURE: _____ **DATE:** _____

Submit this form directly to your insurance provider.