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:** 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.