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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: Eyeweb.com

ADDRESS: 752348300 Falls of Neuse Road Suite 110 Raleigh, NC 27615 USA

CITY: Raleigh

STATE: NC

ZIP:27615

PHONE: (888) 449 9540

ORDER #: ______________________

PURCHASE DATE: ______________________

ITEM(S) PURCHASED: ______________________

FRAMES AMOUNT: ______________________

LENS AMOUNT: ______________________

CONTACT LENS AMOUNT: ______________________

LENS TYPE (IF APPLICABLE):

Single Vision *Progressive* *Bifocal* *Other*

MEMBER SIGNATURE: ______________________ DATE: ______________________

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