eyebuydirect

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: Eyebuydirect.com

ADDRESS: 13515 N. Stemmons Freeway, Dallas, Texas 75234

CITY: Dallas

STATE: TX

ZIP: 75234

PHONE: (855)393-2891

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:** ______________________

SUBMIT THIS FORM DIRECTLY TO YOUR INSURANCE PROVIDER