

DIRECT REIMBURSEMENT CLAIM FORM

MEMBER INFORMATION

MEMBER ID #: _____ MAILING ADDRESS: _____
GROUP #: _____ CITY: _____
MEMBER NAME: _____ STATE: _____
DATE OF BIRTH: _____ ZIP: _____
PHONE: _____

PATIENT INFORMATION

RELATIONSHIP TO MEMBER: _____ MAILING ADDRESS: _____
Self ☐ *Spouse* ☐ *Child* ☐ *Other* ☐ CITY: _____
STATE: _____
PATIENT NAME: _____ ZIP: _____
DATE OF BIRTH: _____ PHONE: _____

PURCHASE INFORMATION

PROVIDER: Glasseseasybuy.com ORDER #: _____
ADDRESS: 6547 N Academy Blvd #2266 PURCHASE DATE: _____
CITY: Colorado Springs ITEM(S) PURCHASED: _____
STATE: Co FRAMES AMOUNT: _____
ZIP: 80918 LENS AMOUNT: _____
PHONE: (855)393-2891 CONTACT LENS AMOUNT: _____
LENS TYPE (IF APPLICABLE):
Single Vision *Progressive* *Bifocal* *Other*

MEMBER SIGNATURE: _____ DATE: _____