GlassesUSA.com™

SUBMIT THIS FORM DIRECTLY TO
YOUR INSURANCE PROVIDER

DIRECT REMBURSEMENT CLAIM FORM

MEMBER INFORMATION

MEMBER ID #: _____

GROP #: _____

MEMBER NAME: _____

DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____

STATE: _____

ZIP: _____

PHONE: _____

PATIENT INFORMATION

RELATIONSHIP TO MEMBER:

Self *Spouse* *Child* *Other*

MEMBER NAME: _____

DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____

STATE: _____

ZIP: _____

PHONE: _____

PURCHASE INFORMATION

PROVIDER: GlassesUSA.com

ADDRESS: 954 Lexington Avenue, Suite 537

CITY: New York

STATE: NY

ZIP: 10021-5013

PHONE: (800) 917-7083

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.