

# VISION INSURANCE EYEGLOSS REIMBURSEMENT FORM

## OUT-OF-NETWORK 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 INFORMATION:

**My Eyeglass Store  
2350 Arbor Lane  
Holiday, Utah 84117**

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