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: Luxottica of America Inc.

Address: 4000 Luxottica Place

City: Mason

State: OH

ZIP: 45040

Phone: 513 765 4321

Order #: _____

Purchase Date: _____

Items Purchased: _____

Frames Amount: _____

Lens Amount: _____

Contact Lens Amount: _____

Lens Type (if applicable):

Single Vision *Progressive* *Bifocal* *Other*

Member Signature: _____ Date: _____

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