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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