



SUBMIT THIS FORM DIRECTLY TO YOUR INSURANCE PROVIDER

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: rx-safety.com ORDER: \_\_\_\_\_
ADDRESS: 123 Lincoln Boulevard PURCHASE DATE: \_\_\_\_\_
CITY: Middlesex ITEM(S) PURCHASED: \_\_\_\_\_
STATE: NJ FRAMES AMOUNT: \_\_\_\_\_
ZIP: 08846 LENS AMOUNT: \_\_\_\_\_
PHONE: 1-866-653-5227 LENS TYPE (if applicable):
Single Vision Progressive Bifocal Other

MEMBER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Submit this form directly to your insurance provider.