

**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: FramesDirect.com ORDER #: \_\_\_\_\_  
ADDRESS: 2801 S I-35, Suite 170 PURCHASE DATE: \_\_\_\_\_  
CITY: Austin ITEM(S) PURCHASED: \_\_\_\_\_  
STATE: TX FRAMES AMOUNT: \_\_\_\_\_  
ZIP: 78741 LENS AMOUNT: \_\_\_\_\_  
PHONE: (800) 248-9427 CONTACT LENS AMOUNT: \_\_\_\_\_  
LENS TYPE (IF APPLICABLE):  
*Single Vision Progressive Bifocal Other*

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