glasses gallery

SUBMIT THIS FORM DIRECTLY TO YOUR INSURANCE PROVIDER

DIRECT REIMBURSEMENT CLAIM FORM

MEMBER INFORMATION

Member ID #:

Grop #:

Member Name:

Date of Birth:

Mailing Address:

City:

State:

Zip:

Phone:

PROVIDER INFORMATION

Examiner

Name:

Address:

City:

State:

Zip:

Phone:

Dispenser

Name: **GlassesGallery.com**

Address: **19 Shea Way Suite 307, STE202RD**

City: **Newark**

State: **DE**

Zip: **19713**

Phone: **888-686-2810**

	Date of Service	Expense(s) INcurred
1. Frames		$
2. Single Vision Lenses		$
3. Progressive Lenses		$
4. Bifocal Lenses		$
	Total	**$**

Member Signature: _____ **Date:** _____