**SUBMIT THIS FORM DIRECTLY
TO YOUR INSURANCE
PROVIDER FOR REIMBURSEMENT**

DIRECT REIMBURSEMENT CLAIM INFORMATION

MEMBER INFORMATION

Name: ______________________________________

Address: ____

City: _______________________________________ State: ______________ Zip: ______________

Phone Number: _____________________________ Member # _______________________________

PATIENT INFORMATION

Name: ______________________________________

Address: ____

City: _______________________________________ State: ______________ Zip: ______________

Relationship to Member: Self ☐ Spouse ☐ Child ☐ Other ☐

Full Time Student Yes ☐ No ☐ D.O.B ______________

Reimbursement Request – Please enter amount for each

Eye Exam	Frame	Lenses	Contact
$ ________________	$ _________________	$ ________________	$ ________________

Single Vision ☐ Bi-Focal ☐ Progressive ☐

Date of Service: __________________________

PROVIDER INFORMATION

HEAVYGLARE EYEWEAR
1960 Cliff Lake Road Suite #119
Eagan, MN 55122
888-548-0558
TIN 39-1980442