Please submit this form to your insurance provider

CLAIM FORM FOR DIRECT REIMBURSEMENT

Member Information

Member ID		State	
Group No.		City	
Member Name		Address	
Birth Date(MM/DD/YY)		ZIP Code	
Country		Phone Number	

Patient Information (If it is not self, please complete this part)

Relationship to Member:				State	
Self	Spouse	Kid	Other: ___________	City	
Patient Name				Address	
Birth Date(MM/DD/YY)				ZIP Code	
Country				Phone Number	

Order Information

Provider	Myglassesmart.com	Items Type			
Address	Rm B2-6011,Jiangchun Business Center, No. 830 Wenyi West Road	Order Number			
State	Zhejiang China	Purchase Date			
City	Hangzhou	Order Amount			
ZIP	310000	Lens Type:			
PHONE	86 18301368075	Single Vision	Progressive	Reading	Other:_________

Signature: ____________________

Date: ____________________