HEAVYGLARE Complete Eyewear Solutions®

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
14055 Grand Ave, STE G
Burnsville, MN 55337
888-548-0558
TIN 39-1980442