ADS Sports Eyewear

SUBMIT THIS FORM DIRECTLY TO
YOUR INSURANCE PROVIDER

DIRECT REIMBURSEMENT CLAIM FORM

MEMBER INFORMATION

MEMBER ID #: _____

GROUP #: _____

MEMBER NAME: _____

DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____

STATE: _____

ZIP: _____

PHONE: _____

PATIENT INFORMATION

RELATIONSHIP TO MEMBER:

Self *Spouse* *Child* *Other*

PATIENT NAME: _____

DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____

STATE: _____

ZIP: _____

PHONE: _____

PURCHASE INFORMATION

PROVIDER: ADS Sports Eyewear

ADDRESS: 401 W. Pres. George Bush Hwy, Suite 125

CITY: Richardson

STATE: TX

ZIP: 75080

PHONE: (800) 381-9083

ORDER #: _____

PURCHASE DATE: _____

ITEM(S) PURCHASED: _____

FRAMES AMOUNT: _____

LENS AMOUNT: _____

CONTACT LENS AMOUNT: _____

LENS TYPE (IF APPLICABLE):

Single Vision *Progressive* *Bifocal* *Other*

MEMBER SIGNATURE: _____ DATE: _____

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