NEXTPAIR

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: NextPair

ADDRESS: 24681 SE 46th Terrace, Sammamish, WA 98029

CITY: Sammamish

STATE: Washington

ZIP: 98029

PHONE: (425)533-5357

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:** _____

Submit thiS Form directly to your inSurance provider