NUVOOEYES

Nuvooeyes LLC
Document ID: NVR-001 | Version 1.0

Out-of-Network Vision Reimbursement Claim Form

Complete this form and submit it with your itemized receipt to your vision insurance provider.

PATIENT INFORMATION

FULL LEGAL NAME

DATE OF BIRTH

STREET ADDRESS

CITY

STATE

ZIP CODE

PHONE

INSURANCE INFORMATION

INSURANCE COMPANY

MEMBER ID

GROUP NUMBER

SUBSCRIBER NAME (IF DIFFERENT FROM PATIENT)

SUBSCRIBER DATE OF BIRTH

PURCHASE INFORMATION

PURCHASE DATE

ORDER / INVOICE NUMBER

AMOUNT PAID

PROVIDER / RETAILER

PRODUCT OR SERVICE PURCHASED

REQUIRED ATTACHMENTS

- ☐ Completed claim form
- ☐ Itemized receipt from Nuvooeyes LLC
- ☐ Prescription, if requested by your insurer

PATIENT CERTIFICATION

I certify that the information provided is accurate and complete. I authorize my vision insurance provider to review this claim and contact Nuvooeyes LLC if additional purchase information is required. I understand that Nuvooeyes LLC does not determine eligibility, coverage, reimbursement amounts, or claim approval.

PATIENT / SUBSCRIBER SIGNATURE

DATE