Optical Claim Form

Please use BLOCK CAPITALS and Black Ink when completing the form.

Once completed you can upload this together with a copy of the invoice and your current prescription via our on-line claims portal at www.expacare.com/submit-a-claim. **Please contact us on +44 (0) 1344 233900 if you have any questions.**

First name: Last name:

Telephone: Email:

Membership Number: Date of birth: DD / MM / YY

1. Date of eye test:

2. Has your prescription changed since your last eye test?: Yes ☐ No ☐

Please provide a copy of your current prescription:

Rx	Sphere	Cylinder	Axis	Prism	Add
Right (OD)					
Left (OS)					

3. I have included the following:

Copy of invoice ☐

Copy of current prescription ☐