VISION CLAIM FORM
CABELL COUNTY BOARD OF EDUCATION

9200 US RT 60 * ONA, WV 25545 * (304) 525-0331 * (304) 525-6005 FAX

Employee Social Security No. Employee Last Name Employee First Name M.I.

Home Phone Number Street Address

City, State, Zip Code

Employed By

Are group health insurance benefits payable from any other source for the expenses submitted?

If claim is for **Dependent**, answer the following questions: Dependent Name

Dependent's Social Security No. Date of Birth □ Spouse □ Child

MEDICAL EXAMINER SECTION **(After completion of this form, please attach itemized bills and mail to the Health Fund at the address show above)**

Name of Patient

Was prescription written: Initial glasses or replacement? If replacement, indicate change in distance and/or

Date of Delivery: Lenses Fee Charged:

Frame Fee Charges: Total Cost to Patient:

, 20_____

(PLEASE PRINT, THEN SIGN ABOVE YOUR PRINTED NAME)

Phone Number

Physician's T.I.N. State License Reg. No

(MUST BE FURNISHED UNDER AUTHORITY OF LAW)

EMPLOYEE'S ASSIGNMENT

I authorize the release of information required to process my claim.

Date Signed

(SIGNATURE OF EMPLOYEE)

I authorize payment directly to the provider of service.

Date Signed