VISION CLAIM FORM
CABELL COUNTY BOARD OF EDUCATION

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

EMPLOYEE SECTION

Employee Social Security No.	Employee Last Name	Employee First Name	M.I.
Home Phone Number	Street Address		
City, State, Zip Code		Date of Birth	
Employed By			

Are group health insurance benefits payable from any other source for the expenses submitted?
☐ Yes ☐ No If "Yes," Name ______________________ Policy No. ____________

Address ____

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: ☐ Yes ☐ No	Initial glasses or replacement? ☐ Initial ☐ Replacement	If replacement, indicate change in dipter and degree of axis from prior prescription:
Are lenses for sunglasses? ☐ Yes ☐ No		Date of Prior Prescription:

INDICATE CHARGES FOR SERVICES & MATERIALS:

Examination Date:	Exam Fee Charged:		
Type of Lenses: ☐ Single ☐ Bifocal ☐ Trifocal ☐ Lenticular ☐ Contacts		Date of Delivery:	Lenses Fee Charged:
Frames Date of Delivery:	Frame Fee Charges:	Total Cost to Patient:	

Date ____________________, 20_____ Signed ______________________________, Degree
(PLEASE PRINT, THEN SIGN ABOVE YOUR PRINTED NAME)

Address ____ 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 ____________________, 20______ Signed ______________________________
(SIGNATURE OF EMPLOYEE)

I authorize payment directly to the provider of service.

Date ____________________, 20______ Signed ______________________________
(SIGNATURE OF EMPLOYEE)