

# VISION CLAIM FORM

RETURN THIS FORM TO:  
 Hancock County Board of Education  
 Vision Plan  
 3150 US Route 60  
 Ona, WV 25545

TO BE COMPLETED BY EMPLOYEE			
Name of Employee - Social Security # XXX-XX-	Family _____ Single _____	Sex _____ Age _____	Phone No. _____
Address of Employee	Number & Street	City	State Zip Code
Is the person for whom this claim is being made covered by any other group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Group _____		Policy Number _____	
Name of Insurance Company _____		Address _____	
IF CLAIM IS FOR DEPENDENT ANSWER THE FOLLOWING QUESTIONS			
Name of Dependent	Married _____ Single _____ Sex _____ M _____ F	Date of Birth _____	Relationship _____
Address of Dependent	Employer of Dependent _____		
AUTHORIZATION			
Employer	I authorize release to the above Plan any information required to process my claim. A photocopy of this authorization may be honored.		
Date			_____ Employee's Signature
	I authorize payment directly to the provider of service.		_____ Employee's Signature
TO BE COMPLETED BY DOCTOR			
Patient's Name	Patient's Address _____		
Was Prescription Written <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial Glasses or Replacement? _____		
If Replacement, Indicate Change in Dipter and Degree of Axis From Prior Prescription:			
Are Lenses For Sunglasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Prior Prescription _____		
INDICATE CHARGES FOR SERVICES & MATERIALS:			
Examination: Date _____	Fee Charged: \$ _____		
Lenses Furnished: Date of Delivery _____	Fee Charged: \$ _____		
Indicate Type of Lenses			
Single Vision _____	Bifocal _____	Date of Delivery _____	
Trifocal _____	Lenticular _____		
Contacts _____			
Frames: Date of Delivery _____	Fee Charged: \$ _____		
	Total Cost To Patient: _____	Fee Charged: \$ _____	
Date: _____	State License Reg. No. _____	Tax I.D. No. _____	
Print Signature: _____	Doctor's Address: _____		
Doctor's Signature _____	Doctor's Phone _____		

Please print then sign above your printed name: