VISION CLAIM FORM
AMERICAN BENEFIT CORPORATION

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)