WETZEL COUNTY BOARD OF EDUCATION
VISION PLAN

Return This Form To:

Wetzel County Board of Education
Vision Plan
3150 Rt. 60
Ona, WV 25545

VISION CARE CLAIM FORM

TO BE COMPLETED BY EMPLOYEE

NAME OF EMPLOYEE	☐ MARRIED ☐ SINGLE	SEX AGE	PHONE NO.
ADDRESS OF EMPLOYEE — NUMBER AND STREET — CITY — STATE — ZIP CODE			SOCIAL SECURITY NUMBER
ARE GROUP HEALTH INSURANCE BENEFITS PAYABLE FROM ANY OTHER SOURCE FOR THE EXPENSES SUBMITTED? ☐ YES ☐ NO	IF "YES" (A) INSURING ORGANIZATION (B) EMPLOYER		

IF CLAIM IS FOR DEPENDENT ANSWER THE FOLLOWING QUESTIONS

NAME OF DEPENDENT	☐ MARRIED ☐ SINGLE	SEX AGE	RELATIONSHIP
ADDRESS OF DEPENDENT	EMPLOYER OF DEPENDENT		

AUTHORIZATION

EMPLOYER	I AUTHORIZE RELEASE TO WETZEL COUNTY BOARD OF EDUCATION PLAN OF ANY INFORMATION I 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? ☐ YES ☐ NO	INITIAL GLASSES OR REPLACEMENT?
IF REPLACEMENT, INDICATE CHANGE IN DIOPTER AND DEGREE OF AXIS FROM PRIOR PRESCRIPTION:	
ARE LENSES FOR SUNGLASSES? ☐ YES ☐ NO	DATE OF PRIOR PRESCRIPTION

INDICATE CHARGES FOR SERVICES & MATERIALS:

EXAMINATION: DATE — FEE CHARGED: $ _____

LENSES FURNISHED: DATE
SHOW TYPE BY CHECK MARK.

FEE CHARGED: $ _____

SINGLE VISION _____ BIFOCAL _____

TRIFOCAL _____ LENTICULAR _____ DATE OF DELIVERY: _____

CONTACTS _____

FRAMES: DATE — FEE CHARGED: $ _____

TOTAL COST TO PATIENT: FEE CHARGED: $ _____

DATE: STATE LICENSE REG. NO. TAX I.D. NO.

DOCTOR'S SIGNATURE DOCTOR'S ADDRESS