

VISION CLAIM FORM

RETURN THIS FORM TO:
 Nicholas County Board of Education
 Vision Plan
 3150 US Route 60
 Ona, WV 25545 **304.7813911**

TO BE COMPLETED BY EMPLOYEE

Name of Employee - Social Security # XXX-XX-	<input type="checkbox"/> Family <input type="checkbox"/> Single	Sex <input type="checkbox"/> Age <input type="text"/>	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	<input type="checkbox"/> Married <input type="checkbox"/> Single Sex <input type="checkbox"/> M <input type="checkbox"/> 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
	_____ 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	Fee Charged: \$ _____
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: