VISION CLAIM FORM

RETURN THIS FORM TO:
Doddridge 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? ____ Yes ____ 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. ______________________ Employee's Signature
Date	______________________ 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 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   Fee Charged: $

Lenses Furnished: Date of Delivery
Indicate Type of Lenses   Fee Charged: $______________
Single Victor ____________ Bifocal ____________
Trifocal ____________ Lenticular ____________ Date of Delivery ____________
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: