PUTNAM COUNTY BOARD OF EDUCATION

DENTAL AND VISION BENEFIT PLAN

VISION CARE CLAIM FORM

RETURN THIS FORM TO

AMERICAN BENEFIT CORP
P.O. BOX 2648
HUNTINGTON, WV 25726
(304) 525-0331

TO BE COMPLETED BY EMPLOYEE

NAME OF EMPLOYEE ☐ MARRIED ☐ SINGLE SEX ___ AGE PHONE NO.

ADDRESS OF EMPLOYEE NUMBER AND STREET CITY STATE ZIP CODE

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

I AUTHORIZE RELEASE TO PUTNAM COUNTY BOARD OF EDUCATION VISION PLAN OF ANY INFORMATION REQUIRED TO PROCESS MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED

____
EMPLOYEE SIGNATURE

I AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER OF SERVICE

DATE:

____
EMPLOYEE SIGNATURE

____
SOCIAL SECURITY NO.

TO BE COMPLETED BY DOCTOR

PATIENT NAME PATIENT 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 AND MATERIALS

EXAMINATION DATE ______________________________ FEE CHARGED $ ____________

LENSES FURNISHED

SHOW TYPE BY CHECK MARK

SINGLE VISION ___ BIFOCAL ___ TRIFOCAL ___ LENTICULAR ___ CONTACTS ___

DATE OF DELIVERY ______________________________

FRAMES DATE FEE CHARGED $ ____________

TOTAL COST TO PATIENT FEE CHARGED $ ____________

DOCTOR SIGNATURE ______________________________ STATE LICENSE REG TAX I.D. NO.

DOCTOR ADDRESS ______________________________