# VISION CLAIM FORM

## RETURN THIS FORM TO:

**American Benefit**
**9200 US Route 60**
**Ona, WV 25545**

### TO BE COMPLETED BY EMPLOYEE

| Name of Employee | Social Security Number 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

Date

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

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 Vision _____ Bifocal _____

Trifocal _____ Lenticular _____ Date of Delivery _____

Contacts _____

Frames: Date of Delivery — Fee Charged: $

Date: — Total Cost To Patient: _____ — Fee Charged: $_____
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.