VISION CLAIM FORM

RETURN THIS FORM TO:
Mingo Board of Education
Vision Plan
3150 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	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 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.