# VISION CLAIM FORM
# AMERICAN BENEFIT CORPORATION

**9200 US RT 60 * ONA, WV 25545 * (304) 525-0331 * (304) 525-6005 FAX**

**EMPLOYEE SECTION**

| Employee Social Security No. | Employee Last Name | Employee First Name | M.I. |
|---|---|---|---|
| Home Phone Number | Street Address | | |
| City, State, Zip Code | | Date of Birth | |
| Employed By | | | |

Are group health insurance benefits payable from any other source for the expenses submitted?
□ Yes □ No If "Yes," Name _____ Policy No. _____

Address _____

If claim is for **Dependent**, answer the following questions: Dependent Name_____

Dependent's Social Security No. _____ Date of Birth _____ □ Spouse □ Child

**MEDICAL EXAMINER SECTION** **(After completion of this form, please attach itemized bills and mail to the Health Fund at the address show above)**

Name of Patient _____

| Was prescription written: □ Yes □ No | Initial glasses or replacement? □ Initial □ 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: | Exam Fee Charged: | | |
|---|---|---|---|
| Type of Lenses: □ Single □ Bifocal □ Trifocal □ Lenticular □ Contacts | | Date of Delivery: | Lenses Fee Charged: |
| Frames Date of Delivery: | Frame Fee Charges: | Total Cost to Patient: | |

Date _____, 20_____ Signed _____, Degree
(PLEASE PRINT, THEN SIGN ABOVE YOUR PRINTED NAME)

Address _____ Phone Number _____

Physician's T.I.N. _____ State License Reg. No _____
(MUST BE FURNISHED UNDER AUTHORITY OF LAW)

**EMPLOYEE'S ASSIGNMENT**

I authorize the release of information required to process my claim.

Date _____, 20_____ Signed _____
(SIGNATURE OF EMPLOYEE)

I authorize payment directly to the provider of service.

Date _____, 20_____ Signed _____
(SIGNATURE OF EMPLOYEE)