

\_\_\_ *I wish to pick up my check.*

**Vision Reimbursement Program  
Reimbursement Request Form**

\_\_\_ *I wish to have my check mailed.*

Employee Name \_\_\_\_\_ ID# \_\_\_\_\_ Phone Ext \_\_\_\_\_ Employee Group \_\_\_\_\_

**Patient's Information**

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Relationship \_\_\_\_\_

**Services**

Date of Service(s) \_\_\_\_\_

**Glasses**

Examination \$ \_\_\_\_\_

Lenses:

Single Vision \$ \_\_\_\_\_

Bifocal \$ \_\_\_\_\_

Trifocal \$ \_\_\_\_\_

Lenticular \$ \_\_\_\_\_

Frames \$ \_\_\_\_\_

**\*\*OR\*\***

**Contacts** - including exam (in lieu of glasses)

Medically Necessary \$ \_\_\_\_\_

(Please provide documentation of medically necessary contacts)

Cosmetic \$ \_\_\_\_\_

<b><u>Human Resources Use Only - Amount of Charges Reimbursed</u></b>	
	<b><u>Maximum Coverage</u></b>
\$ _____	\$ 45.00
\$ _____	\$ 55.00
\$ _____	\$ 80.00
\$ _____	\$ 100.00
\$ _____	\$ 120.00
\$ _____	\$ 65.00
\$ _____	
\$ _____	\$ 200.00
\$ _____	\$ 125.00

***Please submit an itemized statement of services rendered, receipt(s) indicating what was paid and this form to the Human Resources Office.  
Requests for reimbursement must be submitted within six months of the date of service.***

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

<b><u>Human Resources Use Only</u></b>		
Account Number _____	Requisition Number _____	Amount Reimbursed _____
Human Resources Authorization _____	Date _____	