

___ *I wish to pick my check up.*

***Vision Reimbursement Program
Reimbursement Request Form***

___ *I wish to have my check mailed.*

Employee Name _____ ID# _____ Phone Ext _____ Employee Group _____

Patient's Information

Name _____ Birthdate _____ Relationship _____

Itemized Statement Of Services

Date of Service(s) _____

Examination \$ _____

Lenses:

Single Vision \$ _____

Bifocal \$ _____

Trifocal \$ _____

Lenticular \$ _____

Frames \$ _____

OR

Contacts Including Exam (in lieu of glasses)

Medically Necessary \$ _____

Cosmetic \$ _____

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

***Please submit itemized statement or receipts of services rendered along with this form to the Human Resources Office.
Requests for reimbursement must be submitted within six months of the date of service.***

Employee Signature _____ Date _____

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