

**HANCOCK COUNTY SCHOOLS  
DENTAL AND VISION BENEFIT PLAN**

RETURN THIS FORM TO:  
**HANCOCK COUNTY SCHOOLS  
 DENTAL AND VISION BENEFIT PLAN  
 P.O. BOX 2628  
 HUNTINGTON, WV 25726-2628**

**VISION CARE CLAIM FORM**

**TO BE COMPLETED BY EMPLOYEE**

NAME OF EMPLOYEE – SOCIAL SECURITY NUMBER		<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	SEX AGE	PHONE NO.
ADDRESS OF EMPLOYEE	NUMBER AND STREET	CITY	STATE	ZIP CODE
ARE GROUP HEALTH INSURANCE BENEFITS PAYABLE FROM ANY OTHER SOURCE FOR THE EXPENSES SUBMITTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF "YES" (A) INSURING ORGANIZATION (B) EMPLOYER		

**IF CLAIM IS FOR DEPENDENT ANSWER THE FOLLOWING QUESTIONS**

NAME OF DEPENDENT	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	SEX AGE	RELATIONSHIP
ADDRESS OF DEPENDENT	EMPLOYER OF DEPENDENT		

**AUTHORIZATION**

EMPLOYER	I AUTHORIZE RELEASE TO HANCOCK COUNTY BOARD OF EDUCATION VISION PLAN OF 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
DATE	

**TO BE COMPLETED BY DOCTOR**

PATIENT'S NAME	PATIENT'S ADDRESS
WAS PRESCRIPTION WRITTEN? <input type="checkbox"/> YES <input type="checkbox"/> NO	INITIAL GLASSES OR REPLACEMENT?
IF REPLACEMENT, INDICATE CHANGE IN DIOPTR AND DEGREE OF AXIS FROM PRIOR PRESCRIPTION:	
ARE LENSES FOR SUNGLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF PRIOR PRESCRIPTION

**INDICATE CHARGES FOR SERVICES & MATERIALS:**

EXAMINATION:	DATE	FEE CHARGED: \$ _____
LENSES FURNISHED: <u>DATE OF DELIVERY</u> SHOW TYPE BY CHECK MARK.		FEE CHARGED: \$ _____
SINGLE VISION _____	BIFOCAL _____	
TRIFOCAL _____	LENTICULAR _____	DATE OF DELIVERY _____
CONTACTS _____		
FRAMES:	<u>DATE OF DELIVERY</u>	FEE CHARGED: \$ _____
		TOTAL FEE CHARGED: \$ _____
DATE:	STATE LICENSE REG. NO.	TAX I.D. NO.
DOCTOR'S SIGNATURE	DOCTOR'S ADDRESS	

