Nicholas County Board of Education

Vision Benefit Plan – Claim/Reimbursement Form

POLICYHOLDER/PROVIDER: ***ENTIRE FORM MUST BE COMPLETED, RECEIPTS INCLUDED, and RETURNED TO:***
AMERICAN BENEFIT CORPORATION, *Claims Administration* 9200 US Route 60, East, Ona, WV 25545-9508
Claim forms not completed in their entirely and/or submitted without receipts, WILL BE RETURNED, resulting in a delay of payment/reimbursement.

Policyholder - Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Social Security #: _____

☐ Married ☐ Single ☐ Male ☐ Female

☐ Age: _____

Are group Health Insurance Benefits Payable from any other source for the expenses submitted? ☐ Yes ☐ No

If so, please list employer/insurer: _____

_____

➪ ***If this claim/reimbursement is for a Dependent, please answer the following questions:***

Dependent - Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Social Security #: _____

☐ Married ☐ Single ☒ Male ☐ Female

☐ Age: _____

Are group Health Insurance Benefits Payable from any other source for the expenses submitted? ☐ Yes ☐ No

If so, please list employer/insurer: _____

_____

➪ POLICYHOLDER'S AUTHORIZATION *(sign only one)*

For reimbursement to policyholder:

I authorize release to Nicholas County Board of Education Vision Plan of any information required to process my claim, a photocopy of this authorization may be honored.

_____
Policyholder's Signature

For payment to vision provider:

I authorize payment directly to the provider of service.

_____
Policyholder's Signature

➪ TO BE COMPLETED BY DOCTOR

Patient's Name: _____

Initial Glasses or Replacement? _____

If replacement, indicate change in diopter and degree of axis from prior prescription:

Was a Prescription written? ☐ Yes ☐ No

Date of Prior Prescription: _____

Are lenses for sunglasses? ☐ Yes ☐ No

➪ PLEASE INDICATE CHARGES FOR SERVICES/MATERIALS:

Examination Date: _____ Fee: $_____

Frames - Delivery Date: _____ Fee: $_____

Lenses furnished: ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Lenticular ☐ Transitions ☐ Contacts

Delivery Date: _____ Fee: $_____

TOTAL COST TO PATIENT: $_____ Date: _____

Physician's Signature: _____

Physician's Address: _____

State License Reg. #: _____ ***Tax ID #:*** _____