

Wood County Health Benefits Program Vision Services Claim Submission Form

Employee Name: _____ Soc.Sec.# _____
Employee Department: _____ Group# _____
Employee Work Phone: _____ Home Phone: _____

Service Recipient Information

Name of Person Receiving Services: _____ Soc.Sec.#: _____
Relationship to employee: _____
Name of Service Provider: _____
Street: _____
City: _____ State: _____ Zip Code: _____

Please Attach: Original, Detailed Invoice and Sales Receipt, Including Patient Name (Shipping/Billing Information is not sufficient), Date of Service, Proof of Payment, and Itemized Listing of Goods and/or Services. All paperwork must be submitted to the Commissioners' Office through your group benefits representative. Details outlining vision coverage may be found in the Subscriber Booklet.

Services to be Reimbursed (All appropriate information must be completed)

Date of Service: (Mo.) _____ (Day) _____ (Year) _____

() Eye Examination:	Amount \$	_____
() Frame Charges:	Amount \$	_____
() Lens Charges:	Amount \$	_____
() Contact Lens Charges:	Amount \$	_____
() Refractive Surgery (Lasik):	Amount \$	_____
() Tax:	Amount \$	_____
Total Amount:	\$	_____

I request the full amount of reimbursement available. Yes No If No, amount requested _____
Was this care related to a work related injury? Yes No
Is this claim eligible for primary coverage elsewhere? Yes No

I hereby certify that the attached vision services invoice(s) have not been filed for reimbursement and/or payment with any other program. I understand that the Wood County Employees Vision Services Program reimburses only as primary payer of eligible vision services.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature: _____ Date: _____

White - submit with claim Yellow - department copy

For Commissioners' Office Use Only*

*Returned for: _____