VISION CLAIM FORM

Washingtonville Central Schools
c/o Zenith American Solutions
PO BOX 5817
Wallingford, CT 06492
Tel: (800) 827-1703

1. EMPLOYEE'S NAME			2. SOCIAL SECURITY NO.
3. EMPLOYEE'S MAILING ADDRESS	(CITY)	(STATE OR PROVINCE)	(ZIP CODE)
4. PATIENT NAME (IF A DEPENDENT)	5. RELATIONSHIP to EMPLOYEE	6. BIRTH DATE MO. DA. YR.	7. TEL. NO.
8. DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES ☐ NO ☐ IF YES, PLEASE IDENTIFY			

SERVICES PROVIDED

Eye examination, including Refraction $ _____

Other (describe) _____

PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Add for Reading
Right					

Did patient have eyeglasses prior to date of your examination? YES ☐ NO ☐

If Yes, is prescription for new lenses different from that of lenses being replaced? YES ☐ NO ☐

DATE OF THIS EXAMINATION _____

SIGNED _____ DEGREE _____ DATE _____

ADDRESS _____ PHONE _____

PROVIDER T.I.N. # _____

TO BE COMPLETED BY PROVIDER OF MATERIALS Lenses For One Eye ☐ Both Eyes ☐

MATERIALS PROVIDED

Single Vision $ _____ Bifocal $ _____ Trifocal $ _____ Contact $ _____ Sunglasses $ _____ Other $ _____

If contact lenses prescribed, give reason _____

Describe and indicate charge for special features such as hardening, tinting, plastic lenses, etc. - indicate separately from lens charge.

_____ $ _____

Frames
All plastic, standard weight, style and hinges _____ $ _____
Combination metal and plastic _____ $ _____
All metal _____ $ _____
Other, describe _____ $ _____
Other materials, describe _____ $ _____

Are existing frames being used for the new lenses? YES ☐ NO ☐

If no, give reason _____

SIGNED _____ DEGREE _____ DATE _____

ADDRESS _____

PROVIDER T.I.N. # _____

* If examining doctor provides glasses, only one signature is necessary.

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

_____ DATE _____
SIGNED (PATIENT, OR PARENT IF MINOR)

AUTHORIZATION TO PAY BENEFIT TO PHYSICIAN: I hereby authorize payment directly to the above physician for vision benefits otherwise payable to me for his services described on this form, but not to exceed the reasonable and customary fee for this service.

SIGNED _____