

WILSON AREA SCHOOL DISTRICT
VISION REIMBURSEMENT REQUEST FORM

Please complete form and attach a copy of your original itemized receipt which includes a breakdown of the services and or materials received (i.e. eye examination, single vision lenses).

<i>EMPLOYEE INFORMATION</i>
Employee Name: _____
Employee Type <input type="checkbox"/> * Professional <input type="checkbox"/> Support Staff <input type="checkbox"/> ACT 93 <input type="checkbox"/> Executive Secretary
Employee Building/Department: _____
*Reimbursement for purchases/services rendered for the applicable contract year September 1 through August 31.

<i>PATIENT INFORMATION</i>
Patient Name: _____
Relationship to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent - Dependent Date of Birth: _____

<i>PROVIDER INFORMATION</i>		
Provider Name: _____		
Street Address: _____		
City: _____	State: _____	Zip: _____
SERVICE	DATE OF SERVICE	\$ EXPENSE INCURRED
Eye Examination	___/___/___	\$ _____
Frames	___/___/___	\$ _____ Single
Vision Lenses	___/___/___	\$ _____ Bifocal
Lenses	___/___/___	\$ _____
Contact Lenses	___/___/___	\$ _____

Employee Signature: _____

Date: _____

Submit completed form and receipt to the Administration Building - Accounts Payable Department