HUMAN RESOURCES / BENEFITS ADMINISTRATION

Radnor Township School District • 135 S. Wayne Avenue • Wayne, PA 19087
(610) 688-8100, ext. 6057 • Fax (610) 386-6135

Vision Reimbursement Claim Form

Please print clearly. An original receipted invoice from the physician or provider must accompany all claims. Copies of receipts will not be accepted.

Employee Name: ____ Building/Dept: ______________

Address: ____

City/State: ____ Zip+4: ____________________

Patient Name: ______________________________ Relationship to Employee: ________________

Physician or Provider Name: ____

Service Charges - Please provide the charges on the corresponding line.

Exam:	$______________	Date of Service	_____________
Glasses:	$______________	Purchase Date	_____________
Frames:	$______________	Purchase Date	_____________
Lenses:	$______________	Purchase Date	_____________
Contacts:	$______________	Purchase Date	_____________
Total Cost:	**$______________**		

I acknowledge that any amounts received by me as a result of this claim shall be a reimbursement of an approved vision care expense and is not compensation for services performed for Radnor Township School District. Furthermore, I certify that reimbursement claim expenses have been incurred and paid by me, my spouse, or my dependent(s), and have not or will not be reimbursed from any other source and have not or will not be used by me, my spouse or my dependent(s) as deductions for filing income tax returns.

Employee Signature: __________________________________ Date: ____________________

Office Use Only

Amount Approved: $______________ Vendor # ________ Remittance Location: ____________

Account/s: 10 - __ __ __ __ - 275 - __ __ __ - __ __ - __ __ - __ __ __ ASN _______ %________

10 - __ __ __ __ - 275 - __ __ __ - __ __ - __ __ - __ __ __ ASN _______ %________

Approver: ____ Date: ____________________

Final Approver: ____________________________________ Date: ____________________