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: _____

Address: _____

City/State: _____ Zip+4: _____

Patient Name: _____ Relationship: _____

Physician or Provider Name: _____

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

Exam: _____

Glasses: _____

Frames: _____

Lenses: _____

Contacts: _____

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.

Employee Signature: _____ Date: _____

Office Use Only

Amount Approved: $_____ Vendor # _____ Remittance Location: _____

Account No: 10 - ___ ___ ___ ___ - 275 - ___ ___ ___ - ___ ___ - ___ ___ - ___ ___ ___ ASN _____

Approver: _____ Date: _____

Final Approver: _____ Date: _____