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

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For Commissioners' Office Use Only*

*Returned for: ____