VISION CARE PROGRAM REIMBURSEMENT

I certify that this bill represents a valid claim for reimbursement for vision care received by me/or my eligible dependent(s) and is the only claim requested during the eligibility period for me or my eligible dependent(s) so named. Please place a check for the services performed.

Employee:________________________________ Eye Exam Glasses/Contact Lenses

Co-Payment Bi/Trifocal Lenses

Dependent:________________________________ Eye Exam ☐ Glasses/Contact Lenses

Co-Payment Bi/Trifocal Lenses

Dependent:________________________________ ☐ Eye Exam ☐ Glasses/Contact Lenses

☐ Co-Payment ☐ Bi/Trifocal Lenses

Employee Name:____

Employee Signature:____

Banner ID:_____________________________________ Date:____________________________

Phone Number or Ext:____________________________

Please Note: Original receipts from the vision care provider with the patient's name, the service rendered and the amount paid for each service must be attached to this certificate and submitted to Human Resources. Employee will only be reimbursed for one type of lense glasses or contacts.

Human Resources:

☐ Denied

At this time, you are ineligible for reimbursement. Our records indicate your last reimbursement was on: _______________________.

☐ Approved

Sent to Payroll on: ____

Amount: ____

Approval By: ____