Harrisburg R-VIII School District

Vision Insurance Claim Form

Part A: To be completed by insured.

About the Claimant *One claim form per person.*

Employee Name (Print): ____

Patient Name (Print): ______________________________ Age: __________

Is this claim for a dependent child? Yes___ No___. If yes Date of Birth: ____________
Coverage for dependent children terminates the last day of the month in which they become 25 years old.

Relationship to Employee: ____

About This Claim *Attach a copy of your itemized statement.*

Name of Doctor/Specialist: ____

Total Cost of Exam: $________________ Date of Service: ________________

Total Cost of Lens/Frames: $____________ Date of Service: ________________

Is this claim a result of an accident at work? Yes ________ No ________

Is this claim covered by any other insurance coverage? Yes _________No ________

Employee Signature: ______________________________ Date: __________

Mail completed claim form and a copy of the itemized statement to:

Harrisburg R-VIII School District, c/o Dawn Malone
1000 South Harris, Harrisburg, MO 65256
Telephone: (573) 875-5604 Fax: (573) 875-8877

Part B: To be completed by Harrisburg R-VIII Vision Coordinator.

The coverage pays $45.00 maximum for the exam and 75% on lens and frames up to $200 maximum per insured per year for those covered more than one year. If less than a year of coverage, 50% is paid for lens and frames.

Exam Fee Pd (Max $45.00)	Lens/Frames (50% or 75%)	Total Check Amount	Check #	Date

Coverage Details: One Year Plus _____ Less Than One Year _____

Benefits Administered by: ____
Dawn Malone, District Bookkeeper, Harrisburg R-VIII School District