Vision Reimbursement Claim Form

*For Eligible ACT 93, Non-Union, ESPA, and Head Start Employees Only

Employee & Patient Information

Employee's Name		Employee's Date of Birth
Employee Number	Employment Location	Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child
Patient's Name		Patient's Date of Birth
Employee's Home Address		
City	State	Zip Code

Provider/Service Information

Provider/Supplier's Name		Date of Service/Purchase
Provider's Address		
City	State	Zip Code
Total Cost of Service/Purchase		

Purchase Type ☐ Eye Exam ☐ Eye Glasses Purchase ☐ Contact Lens Purchase ☐ Other (describe) ____________

DCIU Disclaimer

A copy of your receipts must be attached to this form in order for the claim to be processed. Failure to provide all required information may delay your reimbursement payment. Vision reimbursements will only be made for purchases made during the fiscal year in which you are eligible for the benefit (ex. if we are in the benefit period of 2016-2018, the purchase must occur between 7/1/2016 and 6/30/2018. Benefits will be paid directly to the employee only. Please submit claim form to:

Delaware County Intermediate Unit
Attention: Vision Claims– HR Benefits Office
200 Yale Avenue
Morton, PA 19070

610-938-9000 ext. 2003

DO NOT FAX CLAIM FORM

I hereby agree by signing this authorization that any payment made in accordance with the benefit amount of this plan shall constitute a complete release of the Delaware County Intermediate Unit (DCIU) of all liability to the extent of such payment and that I am financially responsible for charges not covered by this authorization or in excess of the benefits provided by this plan.

Employee Signature	Date

Release of Information

I hereby authorize any provider of services (hospital, physician, or other person who has attended me, including insurance companies or other organizations), to furnish the Delaware County Intermediate Unit (DCIU) or its authorized representatives, any and all information with respect to any illness or injury, medical history, consultation, prescription, treatment or predetermination of services, including a copy of any or all hospital or medical records or plan. A photo copy of this authorization shall be considered as effective and valid as the original. I further certify that the information furnished by me in support of this claim is true and correct.

Employee Signature	Date

FOR OFFICE USE ONLY

Amount Available	Amount Approved	Approved By	Date Approved

2016