Atlantic Cape Community College
Vision Care Claim Form

Please type or print neatly. Use one form for each provider.

Employee Name	CWID #
Address	Phone
City/State	Zip
Department	Department Budget #

Patient Name	Birthdate____/____/__
Relationship to Employee: self spouse child dependent	Student ? Yes No

Item/Service	**Amount Paid**	**Amount Owed**	**Office Use Only**
Examination			
Frames			
Lenses: SV BIF TRI LENT CL			
Total			

Provider Name	Service Date
Address	Phone
City/State	Zip

Employee Signature Date Benefits Office Date

Office Use Only
_____ Approved Reason:
_____ Disapproved

Date of next Item/Service
Examination:_____Frames:_____Lenses:_____

Submit complete form and all receipts to Human Resources Rev 11/13 Vision. Form