Atlantic Cape Community College
Vision Care Claim Form

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

Employee Name	SS#
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 3 copies of completed form and all receipts to Benefits Office. Rev 4/01 Vision.frm