	Plan Name:	Return this form to the claims processor:
VISION CLAIM FORM	**WEST VIRGINIA ASSOCIATION OF COUNTIES DENTAL AND VISION BENEFIT PLAN**	**Benefit Assistance Corporation** PO Box 950, Hurricane, WV 25526 Phone: (304)562-1913
	Plan Administrator and Sponsor: **WEST VIRGINIA ASSOCIATION OF COUNTIES**	Electronic Claims Submission: www.eedi.net Clearinghouse ID: 135221807

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME			SOCIAL SECURITY OR MEMBER ID NUMBER	
EMPLOYEE ADDRESS	NUMBER AND STREET	CITY	STATE	ZIP CODE
☐ MARRIED ☐ SINGLE	SEX ☐ MALE ☐ FEMALE	DATE OF BIRTH	TELEPHONE NUMBER	
ARE GROUP HEALTH INSURANCE BENEFITS PAYABLE FROM ANY OTHER SOURCE FOR THE EXPENSES SUBMITTED? ☐ YES ☐ NO		IF "YES": (A) INSURING ORGANIZATION: (B) EMPLOYER:		
(A) WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT? ☐ YES ☐ NO		(B) AN AUTO ACCIDENT? ☐ YES ☐ NO		

IF CLAIM IS FOR DEPENDENT ANSWER THE FOLLOWING QUESTIONS

DEPENDENT NAME			RELATIONSHIP	
DEPENDENT ADDRESS (IF DIFFERENT)	NUMBER AND STREET	CITY	STATE	ZIP CODE
☐ MARRIED ☐ SINGLE	SEX ☐ MALE ☐ FEMALE	DATE OF BIRTH	EMPLOYER OF DEPENDENT	

AUTHORIZATION

I authorize release to West Virginia Association of Counties Dental and Vision Benefit Plan of any information required to process my claim. A photocopy of this authorization may be honored.	I authorize payment directly to the provider of service.
EMPLOYEE'S SIGNATURE	EMPLOYEE'S SIGNATURE

TO BE COMPLETED BY DOCTOR

PATIENT'S NAME				PATIENT'S ADDRESS
WAS PRESCRIPTION WRITTEN?	☐ YES	☐ NO		INITIAL GLASSES OR REPLACEMENT?
IF REPLACEMENT, INDICATE CHANGE IN DIOPTER AND DEGREE OF AXIS FROM PRIOR PRESCRIPTION				
ARE LENSES FOR SUNGLASSES?	☐ YES	☐ NO		DATE OF PRIOR PRESCRIPTION:

INDICATE CHARGES FOR SERVICES & MATERIALS

EXAMINATION:	DATE OF EXAMINATION:	FEE CHARGED: $
LENSES FURNISHED:	DATE OF DELIVERY:	FEE CHARGED: $
(Check One) ☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ LENTICULAR ☐ CONTACTS		
FRAMES:	DATE OF DELIVERY:	FEE CHARGED: $
	TOTAL COST TO PATIENT:	FEE CHARGED: $

DATE:	STATE LICENSE REG. NO.	TAX I.D. NO.
DOCTOR'S SIGNATURE		PRINT DOCTOR'S NAME:
		DOCTOR'S ADDRESS:
		CITY, STATE, ZIP:
		TELEPHONE: