Self-Funded Vision Claim Form

This Vision Claim form is ONLY required if you do not have an itemized receipt.

Employee:___________________________________ **ID:**_________ **Building:**_______________________ **Work Phone:**_____________

Position:_________________ **Address:**____ **City:**_____________________ **Zip:**_________

Name of Patient:____ **Birthdate:**________________**Relationship:**___________________

Eye Doctor/Provider:________________________________ **Address:**____

City:___________________________ **Zip:** _________ **Eye Doctor/Provider Phone:**__________________ **Date of Service:**___________

Costs:

- **Examination:**________________________________
- **Contact Lenses:**______________________________
- **Frame:**______________________________________
- **Lenses:**_____________________________________

Type:

Other (Please explain and list cost.):

Submit original or legible copy of bill and this completed form to:
Human Resources
Lansing School District
519 West Kalamazoo Street
Lansing, MI 48933
517.755.2000