Self-Funded Vision Claim Form

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: Choose One

Other (Please explain and list cost.):

Submit original or legible copy of bill and this completed form to:
Human Resources
hrdept@lansingschools.net