VISION CLAIM FORM

MAIL COMPLETED FORM TO: AVALON BENEFIT SERVICES
P.O. BOX 1803
Dublin, Ohio 43017

PART A - TO BE COMPLETED AND SIGNED BY THE EMPLOYEE

Name of Employee (Please Print)	Social Security Number	
Address/Street & Number	Employer	Group Number
City State Zip	Patient Relationship (Circle One) Self Spouse Son Daughter	Employee Birthday Month Year Day

AUTHORIZATION TO RELEASE INFORMATION	I hereby authorize any insurance company, pre-payment organization, emplopyer, union, trust fund, hospital or physician to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable under this or any other plan provifing benefits or services. A photo copy of this authorization shall be considered as effective and valid as the original.
CERTIFICATION	I certify that the foregoing statements and answers are true and complete to the best of my knowledge and belief. I hereby agree to reimburse this Plan, the amount paid on this claim under any non-occupational plan provision in the event benefits are provided under any Worker's Compensation law or similar legislation.
AUTHORIZATION TO PAY BENEFITS DIRECT	I hereby authorize payment directly to the physician/dispensor of benefits, if any, otherwise payable to me for these services as described below but not to exceed the reasonable and customaty charges. (I understand that I may be financially responsible for charges not paid by my plan.)

Signature of Covered Person	Date

PART B - TO BE COMPLETED BY EXAMINING OPTHALMOLOGIST (M.D.) OR OPTOMETRIST (O.D.)

Name of Patient	Patient Birthday Month Day Year	
Date of Examination Month Day Year	Examination Must Include Refraction. Did it? (Circle One) Yes No	Charge For Examination $
Diagnosis	Remarks	

Doctors Name (Please Print)	Degree
Doctors Street Address	Telephone
City State Zip	
Doctor's Signature	Tax ID No.

PART C - TO BE COMPLETED BY SUPPLIER OF LENSES AND/OR FRAMES

Name of Person For Whom Services Were Porvided (Please Print):

Date Services Provided Month Day Year	Remarks

(Circle One) Lenses Contacts	Single Vision Right Left	Bifocal Right Left	Trifocal Right Left	Charge For Lenses Or Contacts $
Frames Type Of Frame Supplied:				Charge For Frame $

Official Agency Name (Please Print)	Signature Of Supplier
Street Address	Title
City State Zip	Tax ID Number