BERKSHIRE BOARD OF EDUCATION

TREASURER'S OFFICE
P.O. BOX 364
BURTON, OH 44021
(440) 834-4406

OPTICAL REIMBURSEMENT FORM

(BENEFIT PERIOD RUNS FROM SEPT. 1 THROUGH AUGUST 31 FOR EACH SCHOOL YEAR)
ALL CLAIMS MUST BE TURNED IN NO LATER THAN 90 DAYS AFTER THE LAST DAY OF SCHOOL

PATIENT NAME: _____

RELATIONSHIP TO EMPLOYEE: ☐ Self ☐ Spouse ☐ Dependent

EMPLOYEE NAME: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:
I authorize the release of any medical information necessary to process this claim

_____ DATE: _____

NAME OF PHYSICIAN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: _____

DATE(S) OF SERVICE:	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

SIGNATURE OF PHYSICIAN OR SUPPLIER - I CERTIFY THAT THE STATEMENTS ABOVE APPLY TO THE ATTACHED BILLING

_____ Date: _____

PLEASE BE SURE TO ATTACH ALL INVOICES PERTAINING TO THIS CLAIM
THANK YOU!

****** FOR OFFICE USE ONLY ******

CLAIM APPROVED BY: _____ DATE: _____

VENDOR NO. _____ BUDGET ACCOUNT CODE:_____|_____|_____