ALPENA-MONTMORENCY-ALCONA
EDUCATIONAL SERVICE DISTRICT

Application for Vision Service Reimbursement

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Name ____ Date _____________________

Social Security # _____________________________________

I hereby apply for reimbursement of vision services per master agreement. By signature below, I understand that reimbursement to employee shall be provided based upon submission of itemized billing from licensed providers.

ATTACH ITEMIZED BILLING FROM LICENSED PROVIDER.

AMOUNT OF REIMBURSEMENT REQUESTED ________________________________

EMPLOYEE SIGNATURE ____

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Business Office Use:

Amount of Claim Submitted ____

Amount of Request ____

Amount Approved ____

Date of Last Reimbursement ______________________ Amount _______________

Documentation Reviewed By ____

Approved by ____

Account# ____ ________________

C:Word/Vision Reimbursement