



ClaimLinx
 10260 Alliance Road
 Suite 130
 Cincinnati, OH 45242
 (513) 677-6262 or (800) 858-1772 Phone
 (513) 677-6263 or (800) 858-1913 Fax
 www.claimlinx.com

Benefit Administration That's Personal!

Vision Expense Reimbursement Claim Form

NOTE: Please fax or mail and attach a copy of your receipt(s) to process your request.

Today's Date: _____ # Pages _____
(include coversheet)

Company: _____

Employee Name: _____
(Please Print Clearly – First Name, MI, Last Name)

Relationship: S = Self / SP = Spouse / CH = Child

	Date of Service	Claimant Name	Relationship to Employee (Circle)	Vision Expense Type (Circle) OV = Office Visit	Employee Paid Amount	Reimbursement Amount
1			S / SP / CH	OV Glasses Contacts		
2			S / SP / CH	OV Glasses Contacts		
3			S / SP / CH	OV Glasses Contacts		
4			S / SP / CH	OV Glasses Contacts		
5			S / SP / CH	OV Glasses Contacts		
6			S / SP / CH	OV Glasses Contacts		
7			S / SP / CH	OV Glasses Contacts		
		TOTAL				\$

****CONTACT OUR OFFICE IF YOU HAVE ANY QUESTIONS****