RESA 1

Request for Optical Reimbursement

Date of Request: ____________________

Employee: ___________________________________ ID #: ___________________

Address: ___________________________ City: ________________ Zip: _______

Patient: __________________________ Self ____ Spouse _____ Child _____

Age if Patient is Dependent Child: ______

College if Patient is Age 19: ____

Please complete employee information and attach an itemized statement with a paid receipt for the examination and glasses or contact lenses.

Maximum reimbursement benefits paid for optical insurance is $350 every other fiscal year per employee and eligible dependents.

Return to: Michael Click
RESA 1
400 Neville Street
Beckley, WV 25801

Office Use Only

Date(s) of Service: ___________________

Receipt Amount(s): $_______________

Amount Approved
for Reimbursement: $_______________

OK TO PAY

By:__________Date: _____________

Vendor # ________________________

Budget
Code: ___________________________

Approved for Payment by: ___________

Revised 3/10