

ATHENS AREA SCHOOL DISTRICT VISION FORM

This form is available in all school offices and the business office.

Part 1 - Patient (employee) to complete.

Part 2 - Examining doctor to complete.

Part 3 - Dispenser of the prescription to complete.

Part 4 - Business Office to complete.

The patient (employee) is to send this form to the Business Office – marked VISION on the outside of the envelope.

Payments will be approved at the first board meeting of the month.

For prompt payment, forms must be received in the business office no later than 15 days prior to the board meeting.

Vision coverage shall be extended to all employees according to the following schedule:

- A. One complete eye examination in any 12-month period
- B. Lenses in any 12-month period
- C. One set of frames in any 24-month period

The time period for each of the above will begin on the date on which the last benefits were received for the same item. The allowance for frames and lenses may be combined when getting contact lenses (provided the lens time frame allows for frames). Please review your contract for detailed information.

PART 1: TO BE COMPLETED BY EMPLOYEE:

Printed Name of patient/employee:			
Signature of patient/employee:		School:	School Phone:
Home Address:		Home Phone:	

PART 2: TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST:

Diagnosis or Nature of Disease, injury or Vision Disorder:			
Is condition due to injury or sickness arising out of patient employment?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Service:	Medical Services Rendered: (exam, etc.)	Charges	
Does patient require a lens change at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are new frames required	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have prescribed: <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocals <input type="checkbox"/> Trifocals/No-Line Lenses <input type="checkbox"/> Contacts <input type="checkbox"/> Frames			
Type/Print Full Name: _____ Degree: _____		Individual Practitioner-SS#: _____	
Address: _____		All Others - Employer ID #: _____	
Phone: _____		<i>Must be furnished under authority of law</i>	
Signature of Physician: _____			

PART 3: TO BE COMPLETED BY DISPENSER OF PRESCRIPTION:

Date ordered:	Fee for lenses:	Fee for frames:	Fee for contacts:
Type/Print Full Name: _____ Degree: _____		Individual Practitioner-SS#: _____	
Address: _____		All Others - Employer ID #: _____	
Phone: _____		<i>Must be furnished under authority of law</i>	
Signature of Dispenser of Prescription: _____			

PART 4: TO BE COMPLETED BY THE BUSINESS OFFICE: (Please do not write below this line)

Date of this exam:	Date of last exam:
Date of new lenses:	Date of last lenses:
Date of new frames:	Date of last frames:

Coverage	Allowance	Actual Costs
Exam	50.00	
Single Vision Lenses	75.00	
Bi-focal Lenses	110.00	
Tri-focal Lenses / No-line Lenses	125.00	
Frames	90.00	
Total		

Vendor # _____
Account # _____

Date received in the Business Office:	District owes:
Signature of Approval by Business Manager:	Date sent to accounts payable: