ALPENA-MONTMORENCY-ALCONA
EDUCATIONAL SERVICE DISTRICT

Application for ***Vision*** Service Reimbursement

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Name _____ Date _____

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 and proof of payment made to provider.

ATTACH ITEMIZED BILLING FROM LICENSED PROVIDER AND PROOF OF PAYMENT.

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 # _____ _____