



Danville Local Schools
PO Box 30, Danville, OH 43014
Phone Number: 740-599-6116
Fax Number: 740-599-5417

DANVILLE LOCAL SCHOOLS

Employee Eyeglasses or Contact Lenses Expense Claim Form

Instructions:

Complete for unreimbursed Employee Eyeglasses or Contact Lenses expense, then sign and date the bottom of the form. Send completed form along with a fully detailed receipt or Explanation of Benefits (EOB) that contains the date of service, description of services, patient name, provider name, amount charged and any amount paid by insurance (if applicable). You can return the completed form to the Treasurer's Office, fax the completed form, or mail it to the address above. If you have questions, please call the Treasurer's office. We are available Monday through Friday from 8 a.m. to 4 p.m. Please feel free to make copies of this form for future use.

General Information		
Employer	Employee Name	Phone Number
Healthcare Expense Claims (Attach appropriate receipt(s) and submit with this claim form if applicable.)		
Date of Service	Name of Service Provider	Net Amount
Certification and Authorization I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself while I was employed by Danville Local School. I have already received these products and have not been previously reimbursed for these expenses and I will not seek reimbursement of these expenses from any other plan or party. In addition, the expenses for which reimbursement is sought will not be claimed as tax deductions on my personal tax return. I understand that if an expense is determined to be ineligible, I am responsible for reimbursing Danville Local School for any such expense or for payment of all related income taxes on amounts paid from the plan(s) which relate to such expense. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans.		
Employee Signature		Date