

**RALEIGH COUNTY BOARD OF EDUCATION**

**REQUEST FOR OPTICAL REIMBURSEMENT**

Please complete employee information and attach an itemized statement indicating the provider of service along with a paid receipt for the examination, glasses and/or contact lenses.

TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ EMPLOYEE ID 974 / 00 / \_\_\_\_

EMPLOYEE NAME \_\_\_\_\_

STREET/PO BOX \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

NAME OF PATIENT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

AGE (if patient is dependent child) \_\_\_\_\_

NAME OF COLLEGE IF PATIENT IS OVER AGE 19 \_\_\_\_\_

HAVE YOU PROVIDED RCBOE WITH A **CURRENT**  
STUDENT VERIFICATION \_\_\_\_\_

<b>DO NOT WRITE IN THIS BOX</b> <b>CENTRAL OFFICE USE ONLY</b>		
EXAMINATION	\$ _____	DOS ____/____/____
GLASSES OR CONTACT LENS	\$ _____	____/____/____
REIMBURSEMENT TOTAL	\$ _____	
PAY CODE _____	VENDOR _____	

Mail form to: Insurance Department  
Christy Turner  
Raleigh County Schools  
105 Adair Street  
Beckley WV 25801

NOTE: Maximum reimbursement benefits paid for optical insurance is \$300.00 every other fiscal year per employee and eligible dependents.