ClaimLinx
10260 Alliance Road
Suite 130
Cincinnati, OH 45242
Phone (800) 858-1772 or (513) 677-6262
Fax (800) 858-1913 or (513) 677-6263
help@claimlinx.com
www.claimlinx.com

Vision Expense Reimbursement Claim Form

NOTE: Please fax or mail and attach a copy of your receipt(s) to process your request.

Today's Date: _____ **# Pages** _____
(include coversheet)

Company: _____

Employee Name: _____
(*Please Print Clearly – First Name, MI, Last Name*)

Relationship: S = Self / SP = Spouse / CH = Child

	Date of Service	Claimant Name	Relationship to Employee (*Circle*)	Vision Expense Type (*Circle*) OV = Office Visit	Employee Paid Amount	Reimbursement Amount
1			S / SP / CH	OV Glasses Contacts		
2			S / SP / CH	OV Glasses Contacts		
3			S / SP / CH	OV Glasses Contacts		
4			S / SP / CH	OV Glasses Contacts		
5			S / SP / CH	OV Glasses Contacts		
6			S / SP / CH	OV Glasses Contacts		
7			S / SP / CH	OV Glasses Contacts		
		TOTAL				$

****CONTACT OUR OFFICE IF YOU HAVE ANY QUESTIONS****
help@claimlinx.com | (800) 858-1772