Dental-Vision Reimbursement Form

NAME	
BUILDING	

Type of Request: ☐ Dental ☐ Vision

- **APPOINTMENT FOR:** _____
- **APPOINTMENT FOR:** _____
- **APPOINTMENT FOR:** _____
- **APPOINTMENT FOR:** _____

AMOUNT:	
Employee Signature	

ONLY ANSWER THE BOTTOM PORTION OF THIS FORM IF YOU HAVE A SPOUSE & YOUR SPOUSE IS EMPLOYED.

Name of Employer: _____

- Does employer provide dental and or vision coverage?

  ☐ No Coverage ☐ Dental ☐ Vision

- IF employer provides coverage, what age are children covered to?

  ☐ I don't Know ☐ Age 23 ☐ Age _____

Each submission must have a paid invoice, detailed receipt, and an EOB (if necessary).
Email submission to Dental_Vision@wasdpa.org
If you have questions, please contact Chelsea Sanders at Chelsea_Sanders@wasdpa.org or (717)-762-1191 x1144