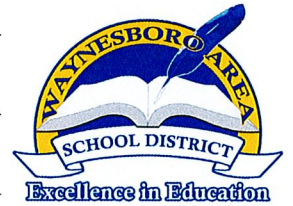


# Dental-Vision Reimbursement Form

<b>NAME</b>	_____
<b>BUILDING</b>	_____



Type of Request:       Dental       Vision

- APPOINTMENT FOR: \_\_\_\_\_
- APPOINTMENT FOR: \_\_\_\_\_
- APPOINTMENT FOR: \_\_\_\_\_
- APPOINTMENT FOR: \_\_\_\_\_

<b>AMOUNT:</b>	_____
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<i>Employee Signature</i>	_____
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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](mailto:Dental_Vision@wasdpa.org)

If you have questions, please contact Chelsea Sanders at [Chelsea\\_Sanders@wasdpa.org](mailto:Chelsea_Sanders@wasdpa.org) or (717)-762-1191 x1144