DETROIT METRO • WILLOW RUN
WAYNE COUNTY AIRPORT AUTHORITY

# OPTICAL REIMBURSEMENT CLAIM FORM

**Benefit Period 12/01/15 thru 11/30/17**

| | | | | | |
|---|---|---|---|---|---|
| **RETIREE NAME (PLEASE PRINT):** | | | | | |
| **HOME ADDRESS:** | | | | | |
| **DAYTIME PHONE#:** | | **LAST FOUR DIGITS OF RETIREE SS#:** XXX-XX- | | | |
| **PERSON RECEIVING SERVICES:** | | | | | |
| **RELATIONSHIP TO RETIREE: (Check one)** | ☐Self | ☐Spouse | ☐Dependent | **BIRTHDATE:** | |
| **CUSTODIAL PARENT NAME:** (IF APPLICABLE) | | | | | |
| **CUSTODIAL PARENT SOCIAL SECURITY NUMBER:** (IF APPLICABLE) | | | | | |
| **CUSTODIAL PARENT HOME PHONE NUMBER:** (IF APPLICABLE) | | | | | |
| **TOTAL AMOUNT OF RECEIPT (S) $** | | **DATE (S) OF SERVICE:** | | | |

**EMPLOYEE SIGNATURE: *** _____ **DATE SIGNED AND SUBMITTED:** _____

***PLEASE READ: BY SIGNING, YOU ARE VERIFYING THAT ALL INFORMATION IS TRUE, OPTICAL RECEIPTS SUBMITTED ARE FOR THE PERSON RECEIVING SERVICES AS STATED ABOVE, AND YOU HAVE NOT BEEN REIMBURSED FOR THE ABOVE OPTICAL RECEIPTS IN ANY OTHER MANNER.**

ALL REIMBURSEMENT REQUESTS MUST BE ACCOMPANIED WITH **LEGIBLE** PAID RECEIPTS SPECIFYING PATIENT'S NAME, DATE OF SERVICE, AND RENDERED SERVICE(S) OR GOOD(S).

**REIMBURSEMENTS MAY TAKE APPROXIMATELY 4-6 WEEKS.**

**RETURN CLAIM FORM AND ORIGINAL RECEIPT(S) TO:**

**WAYNE COUNTY AIRPORT AUTHORITY**
**ATTN: H/R EMPLOYEE BENEFITS**
**1 L.C. SMITH BUILDING-MEZZANINE**
**DETROIT, MICHIGAN 48242**
**734-247-3236**