

Albright College

Inter-County – AmeriHealth Administrators

Group # _____

Vision Reimbursement / Claim Form

Subscriber Name: _____

Subscriber Address: _____

Subscriber ID# _____ Date of Birth: _____

Date of Service _____ Amount _____

Claim is being made for Self
 Covered Dependent

If covered dependent, please provide:

Name _____ Date of Birth _____

Member Signature

Home Phone

Work Phone

Attach receipt for vision exam, glasses, contacts, etc. and mail with completed form to:

Inter-County Health Plan
Attention: Claims
720 Blair Mill Road
Horsham, PA 19044