Prescription Eyeglasses Replacement Form

An application for workers' compensation benefits has been submitted by your employer to SSIF. This form only pertains to your prescription eyeglasses.

NAME _____ **ACCIDENT DATE** _____

ADDRESS _____ **CLAIM #** _____

PHONE _____ **EMAIL** _____

Check the portions below that pertain to your glasses:

Frames		Right Lens		Left Lens		Lens Type		Special Features	
Metal		Broken		Broken		Glass		Scratch Resistant	
Plastic		Scratched		Scratched		Bifocal		Polarized	
Bent		Pitted		Pitted		Trifocal		Blue Light	
Scratched						Progressive		Photochromic	
Broken						Polycarbonate		Anti-Reflective	

PROVIDERS NAME _____ **PROVIDERS PHONE** _____

PROVIDERS ADDRESS _____ **DATE OF LAST EYE EXAM** _____

State employees **MUST** complete and return the WC-00 Form (Prescription Eyeglasses Replacement Form) to our office before payment of charges can be made.

Should you have any additional questions, please contact our office at (785) 296-2364.

State Self Insurance Fund
Mills Building
109 SW 9th St, Suite 600
Topeka, KS 66612-1200

Phone: (785) 296-2364
Fax: (785) 296-6995