CLAIM FORM

CHERRY VALLEY – SPRINGFIELD CENTRAL SCHOOL
PO BOX 485
CHERRY VALLEY, NEW YORK 13320
607-264-3257 EXT 510

TO BE FILLED IN BY VENDOR

(please print)
Name of Vendor___________________________________

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Social Security Number_________________
Or
Employee ID Number__________________
No payment will be made without one of the above numbers!!!!!

Telephone:____________________Date:_______________

Quantity	Unit	Description	Unit Price	Total
_________	**EACH**	**EYE EXAM (UP TO $100.00)**		
_________	**EACH**	**GLASSES, LENSES, CONTACTS (UP TO $100.00)**		
		FOR THE CURRENT FISCAL YEAR JULY 1, 2019 – JUNE 30, 2020		
		PLEASE INCLUDE A COPY OF YOUR RECEIPT THAT SHOWS AMOUNT PAID BY YOU AFTER MEDICARE HAS PAID FOR EXAM.		
		PAYMENT FOR LENSES, FRAMES OR CONTACTS MUST SHOW AMOUNT PAID BY YOU AFTER ANY INSURANCE PAYMENTS.		
		REQUESTS FOR PAYMENT CAN BE MADE AT ANY TIME UP TO JULY 1.		
		THANK YOU		

Invoice Total:____________________

This is to certify that the materials and services charged in the above account or claim and included in the same, have been actually furnished, delivered or performed to the Cherry Valley – Springfield Central School District, Cherry Valley, NY; that said claim is just, due and unpaid and that there are no offsets against the same; that the items and specifications are correct; that the sums charged are reasonable and just; that no New York State Sales Tax has been included; that no payment has been made on account thereof, except as included or referred to in such account or claim. If this claim is for mileage or reimbursement for expenses, then documentation of prior approval is attached. Examples of prior approved are conference request form, requisitions or purchase orders.

______________________	______________	______________________
Vendors Signature	Date	Supervisor
______________________	______________	______________________
Business Office	Purchasing Agent	Claims Auditor