

Out-Of-Network Reimbursement Form



Member Information:

Member's ID or Social Security Number: _____

Member's Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Date of Birth: _____

E-Mail Address: _____

Phone Number: _____

Name of Group/Employer: _____

Patient Information:

Patient's Name: _____

Date of Birth: _____

Relationship to Member: _____

If the patient is a child (and over the age of 18):

Is the child a full time student? Y/N

Name of School: _____

Is the child physically impaired? Y/N

Reimbursement Request Information:

Date Services were received: _____

Services received (please circle any that apply and provide the amount paid for each)

Exam \$ _____

Lenses: Single Vision

Bifocal

Trifocal

Progressive

Lenticular

\$ _____

Lens Options:

Tint

\$ _____

*Other

\$ _____

*(Includes Scratch Coatings, Anti-Reflective coatings, etc.)

Frame \$ _____

Contact Lenses \$ _____

Contact fitting &/or Evaluation \$ _____

Provider/Optical Shop Name: _____

Phone Number: _____

Address: _____

City: _____ State: _____

ZIP Code: _____

Submit this form along with related receipts to:

VSP

P.O. Box 997105, Sacramento, CA 95899-7105

For additional information on your eyecare benefits, please visit our website at: VSP.com