Out-Of-Network Reimbursement Form

Submit this form along with your **itemized receipt to:
VSP P.O. Box 997105, Sacramento, CA 95899-7105

IMPORTANT NOTE:

Your itemized receipt must include the information shown below with an **. If your receipt does not contain this information your claim cannot be processed and you will need to contact your non-VSP provider for a new receipt which includes the required information.

Member Information:

Member's ID or Social Security Number: _____

Member's Name: _____ **Date of birth:** _____

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____ **Phone Number:** _____

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:** _____

For additional information on your eyecare benefits, please contact Customer Service at (800) 877-7195.