Out-Of-Network Reimbursement Form

Member Information:

Member's ID or Social Security Number:___________________________________

Member's Name:____ **Date of Birth:**__________________

Address:____ **E-Mail Address:**_______________

City:______________________________ **State:**_______ **ZIP Code:**____________ **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