

VSP Member Reimbursement Form



To request reimbursement, complete this form (in blue or black ink), enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.

VSP
 PO Box 385018
 Birmingham, AL 35238-5018

Ref #

Member Information

Policyholder/Employee ID or Last 4 Digits of SSN / / Date of Birth

First Name Last Name

Address Apt

City State Zip

() - Daytime Phone # Employer/Group

Patient Information

First Name Last Name

Member Spouse Child Domestic Partner / / Date of Birth

If the patient is a child over the age of 18:

Is the child a full-time student? Yes No Is the child disabled? Yes No

Claim Information (Dollar amounts must match the attached receipts)

Exam \$ <input type="text"/> . <input type="text"/>	Lens Type: (Choose One) Single <input type="checkbox"/> Progressive <input type="checkbox"/>	Date services were received <input type="text"/> / <input type="text"/> / <input type="text"/>
Frame \$ <input type="text"/> . <input type="text"/>	Bi-focal <input type="checkbox"/> Lenticular <input type="checkbox"/>	Check here if another insurance company has made payment to you, another insurer or the doctor's office. <input type="checkbox"/>
Lens \$ <input type="text"/> . <input type="text"/>	Tri-focal <input type="checkbox"/> Contacts <input type="checkbox"/>	
Lens tints \$ <input type="text"/> . <input type="text"/> or coatings		If so, attach a copy of the statement showing payment.
Contacts \$ <input type="text"/> . <input type="text"/>		
Total Paid \$ <input type="text"/> . <input type="text"/> (Do not add tax or shipping)		

Provider Information

L E N S F A S T | L L C

Store or Dr Name

() -

Store or Dr Phone Number

I acknowledge that the above-named provider is not a VSP Preferred Provider and that VSP cannot guarantee eye care and/or eyewear satisfaction. By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information I have provided above is complete and accurate.

Claimant Signature: _____

Date: ___/___/___