Out-Of-Network Reimbursement Form

Member Information:

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

Address:_____

City:_____ **State:**_____ **ZIP Code:**_____

Member's ID or Social Security 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:**_____

Coordination of Benefits Information:

If you are coordinating benefits with another insurance carrier, we need a complete copy of the Explanation of Benefits from your primary insurance carrier. The Explanation of Benefits must indicate the service(s) which were received, as well as the amount paid, denied, or applied to your deductible. This information can be obtained from the provider who performed your recent services.

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