



Out-Of-Network Reimbursement Form

Member Information:

Member's Name: _____ Date of Birth: _____
 Address: _____
 City: _____ State: _____ ZIP Code: _____
 Member's ID : _____
 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

Claims must be submitted no later than six months after receiving services. For additional information on your eyecare benefits, please visit our website at: VSP.com or call Customer Service at 800-877-7195.