VSP Vision care for life

Out-Of-Network Reimbursement Form

Member Information

member's name _____ date of birth _____
address _____
city _____ state ___ZIP _____
member's ID or last 4 digits of SSN _____
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? [yes] [no] name of school _____
[] Is the child physically impaired? [yes] [no]

Reimbursement Request Information

date services were received _____
services received (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 _____ phone _____
address _____
city _____ state ___ZIP _____

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
Or Fax to (916) 858-4985