Out-Of-Network Reimbursement Form

Submit this form along with your **itemized receipt to:
VSP P.O. Box 997105, Sacramento, CA 95899-7105 or
Fax to 916-851-5152

IMPORTANT NOTE:

Your itemized receipt must include the information shown below with an **. If your receipt does not contain this information your claim cannot be processed and you will need to contact your non-VSP provider for a new receipt which includes the required information.

Member Information:

Member's ID or last four digits of Social Security Number:

Member's Name: Date of Birth:

Address:

City: State: ZIP Code: Phone Number:

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? Name of School:

Is the child physically impaired?

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 fittings &/or Evaluation $

****Provider/Optical Shop Name:** **Phone Number:**

Address:

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

For additional information on your eyecare benefits, please contact Customer Service at (800) 877-7195.