Out-of-Network Claim Form

Group Information

Group Name	New West Health Services #12-159329

Policy Holder Information

Policy Holder Name	
Mailing Address	
Daytime Phone Number	( )
Policy Holder ID Number	

Patient Information

Patient Name	
Patient Date of Birth	

IMPORTANT - A copy of your itemized receipt (breakdown of services and for example: lens type with codes) MUST be attached to this claim form.

Members may also contact VSP's customer service department directly at 800-877-7195 for verification of services and the assignment of an authorization number for claim processing.

Please Mail Claim to:

VSP
Attn: Out-of-Network Claims
PO Box 997105
Sacramento, CA 95899-7105

FAX to:

VSP Out-of-Network Claims

916-851-5152