

Out-Of-Network Reimbursement Form



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

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? 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:** _____

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