

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: _____