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.