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? **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 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.