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.