Out-Of-Network Reimbursement Form

Member Information

member's name ______________________ date of birth ______________
address ____
city __________________________ state _____ ZIP __________
member's ID or SSN ________________________________
name of group/employer ______________________________________

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? [yes] [no] name of school ________________
[] Is the child physically impaired? [yes] [no]

Reimbursement Request Information

date services were received ________________
services received (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 ______________________ phone ____________
address ____
city __________________________ state _____ ZIP __________

Submit this form along with related receipts to

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

For more information on your eyecare benefits, please visit VSP.com