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 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.

VSP OUT-OF-NETWORK REIMBURSEMENT DIRECTIONS

Please complete the form, attach your itemized receipts and mail to:

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

Important Note:
In order to process your claim the following information must be provided by the non-VSP provider on the itemized receipt. Your claim cannot be processed if this information is missing.

- the name of the provider
- the name of the patient
- the date of service
- a complete description of each service provided (exam, lens, frame or contacts)
- the amount paid for each service

By enclosing the request for reimbursement form along with your itemized receipt your claim payment is expedited as it ensures we have all of the necessary information. It is important to note that the form is not a substitute for the items listed above, which must be included on the actual itemized receipt from the non-VSP provider. If these items are not on your receipt, you will want to contact your non-VSP provider to obtain a new receipt containing the required information.

Should you have any questions, please contact Customer Service at (800) 877-7195.