

VSP Member Reimbursement Form



To request reimbursement, complete this form (in blue or black ink), enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.

VSP
PO Box 385018
Birmingham, AL 35238-0518

Ref # _____

Member Information

Policyholder/Employee ID or Last 4 Digits of SSN (Your ID# can be found on your BCBS card. Please be sure to include the 3 letter prefix when using your ID#.) _____ Date of Birth _____ / _____ / _____

First Name _____ Last Name _____

Address _____ Apt _____

City _____ State _____ Zip _____

Daytime Phone # (_____) _____ - _____ Employer/Group **Teamsters Local 731 Health and Welfare Funds**

Patient Information

First Name _____ Last Name _____

Member Spouse Child Domestic Partner Date of Birth _____ / _____ / _____

If the patient is a child over the age of 18:

Is the child a full-time student? Yes No Is the child disabled? Yes No

Claim Information (Dollar amounts must match the attached receipts)

Exam \$ _____ . _____	Lens Type: (Choose One) Single <input type="checkbox"/> Progressive <input type="checkbox"/>	Date services were received _____ / _____ / _____
Frame \$ _____ . _____	Bi-focal <input type="checkbox"/> Lenticular <input type="checkbox"/>	Check here if another insurance company has made payment to you, another insurer or the doctor's office. <input type="checkbox"/>
Lens \$ _____ . _____	Tri-focal <input type="checkbox"/> Contacts <input type="checkbox"/>	
Lens tints \$ _____ . _____ or coatings		If so, attach a copy of the statement showing payment.
Contacts \$ _____ . _____		
Total Paid \$ _____ . _____ (Do not add tax or shipping)		

Provider Information

Store or Dr Name _____
Store or Dr Phone Number (_____) _____ - _____

I acknowledge that the above-named provider is not a VSP Preferred Provider and that VSP cannot guarantee eye care and/or eyewear satisfaction. By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information I have provided above is complete and accurate.

Claimant Signature: _____

Date: ____/____/____