



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. *Most out-of-network requests for reimbursement must be submitted to VSP within six months. Please review your group literature or plan information for deadlines and details.*

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: _____