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