

Out-Of-Network Reimbursement Form

Member Information

member's name _____ date of birth _____
 address _____
 city _____ state _____ ZIP _____
 member's ID or last 4 digits of 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 _____

Coordination of Benefits Information

If you are coordinating benefits with another insurance carrier, we need a complete copy of the Explanation of Benefits from your primary insurance carrier. The Explanation of Benefits must indicate the service(s) which were received, as well as the amount paid, denied, or applied to your deductible. This information can be obtained from the provider who performed your recent services.

Submit this form along with related receipts to

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

Or Fax to (916) 858-4985