OUT-OF-NETWORK REIMBURSEMENT FORM

Please complete this form and attach your claim/receipt to it.

VSP Member's Name: ______________________________

VSP Member's ID or Social Security Number: ______________________

VSP Member's Mailing Address: ______________________________ ______________________________

Employer/Health Plan: ______________________________

Member's Date of Birth: ________________

Patient's Name: ______________________________

(If more than one claim, please provide patient name and date of birth on each claim.)

Patient's Date of Birth: ________________

Patient's Relationship to Member: ______________________________

If the patient is a child:

Is the child a full time student?
Yes____ No____

Is child physically impaired?
Yes____ No____

Name of school: ______________________________

Date services were received: ______________________

Services Received (please check the appropriate services and attach an itemized statement of service costs:

- ❑ Exam
- ❑ Frame
- ❑ Contacts
- ❑ Lenses
  (Please circle the lens type below)

  Single Vision Lenses   Bifocal Lenses   Trifocal Lenses

  Progressive Lenses   Lenticular Lenses

Provider's Name: ____

Provider's Address: ____

Provider's Telephone Number: ____

Coordination of Benefits Information:

If you are coordinating benefits with another insurance carrier, please provide us 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. When coordinating benefits, the diagnosis code (ICD-9 code) for eye care services is also needed. This information can be obtained from the provider who performed your most recent eye examination.

Please attach your claim/receipt to this form and mail to
VSP, P.O. Box 997105, Sacramento, CA 95899-7105

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