

# 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.

**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:** \_\_\_\_\_

For additional information on your eyecare benefits, please contact Customer Service at (800) 877-7195.