



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