



Out-Of-Network Reimbursement Form

Member Information:

Member's Name: Date of Birth: Address: City: State: ZIP Code: Member's ID or Social Security Number: 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? 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:

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 within six months from the date of service along with related receipts to: VSP P.O. Box 997105 Sacramento, CA 95899-7105

For additional information on your eyecare benefits, please visit our website at: VSP.com BHT104

10/5/2009