



# 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)

<b>exam</b>		\$ _____
<b>lenses</b>	single vision	
	bifocal	
	trifocal	\$ _____
	progressive	
	lenticular	
	<b>lens options</b>	
	tint	\$ _____
	other*	\$ _____
	*(includes scratch coatings, anti-reflective coatings, etc.)	
<b>frame</b>		\$ _____
<b>contact lenses</b>		\$ _____
	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