

1-800-877-7195
VSP Reimbursement Form



Member Information:

Member's Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ ZIP Code: _____
Employee Number: _____
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)

	Amount Paid
Exam	Maximum Allowed \$75.00 \$ _____
Lenses/Contacts :	
Single Vision	Maximum Allowed \$75.00 \$ _____
Bifocal	Maximum Allowed \$100.00 \$ _____
	Total Due - \$ _____

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 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