



## 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