



Out-Of-Network Reimbursement Form

Submit this form along with your **itemized receipt to:

Vision Service Plan (VSP)
P.O. Box 997105
Sacramento, CA 95899-7105

Important Note:

Your itemized receipt must include the information shown below with an **. If your receipt does not contain this information your claim cannot be processed and you will need to contact your non-VSP provider for a new receipt, which includes the required information.

Member Information:

Member's ID or Social Security Number: Date of Birth:
Member's Name: Phone #:
Address: City: State: Zip Code:

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: **Provider/Optical Shop Phone #:
**Provider/Optical Shop Name:
Address: City: State: Zip Code:

**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 \$
(Frame: \$)
(Contact Lenses: \$)
(Contact fitting &/or Evaluation: \$)
Total: \$