



# VSP Member Reimbursement Form

To request reimbursement, complete this form (in blue or black ink), enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.

VSP  
PO Box 997105  
Sacramento, CA 95899-7105

Ref # \_\_\_\_\_

## Member Information

Member's ID or Last 4 Digits of SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone # (\_\_\_\_\_) \_\_\_\_\_ Employer / Group \_\_\_\_\_

## Patient Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Member  Spouse  Child  Domestic Partner  Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If the patient is a child over the age of 18:

Is the child a full-time student? Yes  No  Is the child disabled? Yes  No

## Claim Information (Dollar amounts must match the attached receipts)

Exam	\$ _____ . _____	Lens Type: (Choose one)	Single <input type="checkbox"/>	Progressive <input type="checkbox"/>	Date services were received _____ / _____ / _____
Frame	\$ _____ . _____		Bi-Focal <input type="checkbox"/>	Lenticular <input type="checkbox"/>	
Lens	\$ _____ . _____	Tri-Focal <input type="checkbox"/>	Contacts <input type="checkbox"/>		Check here if another insurance company has made payment to you, another insurer or the doctor's office. <input type="checkbox"/> If so, attach a copy of the statement showing payment
Lens tints or coatings	\$ _____ . _____				
Contacts	\$ _____ . _____				
Total Paid (Do not add tax or shipping)	\$ _____ . _____				

## Provider Information

Store or Dr Name \_\_\_\_\_

Store or Dr Phone Number (\_\_\_\_\_) \_\_\_\_\_

I acknowledge that the above-named provider is not a VSP Preferred Provider and that VSP cannot guarantee my eyecare and/or eyewear satisfaction. I also attest that the information I have provided above is complete and accurate.

I fully understand and consent to the above statement: \_\_\_\_\_ Date: \_\_\_\_\_

For your protection state law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment is subject to criminal and civil penalties.