VSP Member Reimbursement Form

To request reimbursement, complete and print this form, 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 495918
Cincinnati, OH 45249-5918

PATIENT

Relation to Member*: *(choose one)*

☐ Member ☐ Domestic Partner ☐ Dependent Parent ☐ Disabled Dependent
☐ Spouse ☐ Child ☐ Full-Time Student ☐ Other

Date of Birth*: *(mm/ddyyyy)* _____ Gender*: ☐ Male ☐ Female

Last Name*:_____ First Name*:_____ MI:____

Address*:_____

City*:_____ State*:_____ ZIP*:_____ ZIP+4:_____

MEMBER

Last Four Digits of SSN or Unique ID*: _____

☐ Member information below is the same as Patient

Date of Birth*: *(mm/dd/yyyy)* _____ Gender*: ☐ Male ☐ Female

Last Name*:_____ First Name*:_____ MI:____

Address 1*:_____ Address 2:_____

City*:_____ State*:_____ ZIP*:_____ ZIP+4:_____

CLAIM

Date of Service*: *(mm/dd/yyyy)* _____

☐ Another insurance company made payments to you, another insurer, or the doctor's office. If so, attach a copy of the statement showing payment.

Exam..... $
Frame..... $
Lens..... $
Lens Tints or Coatings..... $
Contact Lens Exam/Fitting Evaluation..... $
Contacts..... $

Lens Type*: *(choose one)*
☐ Single
☐ Bifocal
☐ Trifocal
☐ Progressive
☐ Lenticular

PROVIDER

Last Name:_____ First Name:_____

Office Name:_____

Address 1*:_____ Address 2:_____

City*:_____ State*:_____ ZIP*:_____ ZIP+4:_____

PRINT AND SIGN

I acknowledge that the above-named provider is not a VSP Preferred Provider and that VSP cannot guarantee eye care and/or eyewear satisfaction. By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information I have provided above is complete and accurate.

Claimant Signature:_____ Date:_____