

# 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 385018  
 Birmingham, AL 35238-5018

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

## Member Information

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Policyholder/Employee ID or Last 4 Digits of SSN Date of Birth

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

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

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

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

## Patient Information

\_\_\_\_\_ Last Name  
 \_\_\_\_\_ First 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"/>	Check here if another insurance company has made payment to you, another insurer or the doctor's office. <input type="checkbox"/>
Lens \$ _____ . _____	Tri-focal <input type="checkbox"/> Contacts <input type="checkbox"/>	
Lens tints \$ _____ . _____ or coatings		If so, attach a copy of the statement showing payment.
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 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: \_\_\_\_/\_\_\_\_/\_\_\_\_