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 385018
Birmingham, AL 35238-5018

PATIENT

Relation to Member*: *(choose one)*
◯ Member ◯ Domestic Partner ◯ Dependent Parent ◯ Disabled Dependent
◯ Spouse ◯ Child ◯ Full-Time Student ◯ Other

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

Last Name*: First Name*: MI:

Address*:

City*: State*: ZIP Code*: ZIP+4:

MEMBER

Last 4 Digits of SSN*:

☐ 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 Code*: 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 ◯ Progressive
◯ Bi-focal ◯ Lenticular
◯ Tri-focal

PROVIDER

Last Name: First Name:

Office Name:

Address 1*: Address 2:

City*: State*: ZIP Code*: ZIP+4:

PRINT & 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: _____