



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)

		Lens Type: (Choose one)	Date services were received
Exam	\$ _____ . _____	Single <input type="checkbox"/> Progressive <input type="checkbox"/>	_____ / _____ / _____
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"/> If so, attach a copy of the statement showing payment
Lens	\$ _____ . _____	Tri-Focal <input type="checkbox"/> Contacts <input type="checkbox"/>	
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: _____

