

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/dd/yyyy) _____ 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.....	\$	Lens Type*: (choose one)
Frame.....	\$	☐ Single
Lens.....	\$	☐ Bifocal
Lens Tints or Coatings.....	\$	☐ Trifocal
Contact Lens Exam/Fitting Evaluation.....	\$	☐ Progressive
Contacts.....	\$	☐ 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: _____