

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)			
	<input type="radio"/> Member	<input type="radio"/> Domestic Partner	<input type="radio"/> Dependent Parent	<input type="radio"/> Disabled Dependent
	<input type="radio"/> Spouse	<input type="radio"/> Child	<input type="radio"/> Full-Time Student	<input type="radio"/> Other
	Date of Birth*: (mm/dd/yyyy)	Gender*:	<input type="radio"/> Male	<input type="radio"/> Female
	Last Name*:	First Name*:	MI:	
Address*:				
City*:	State*:	ZIP Code*:	ZIP+4:	

MEMBER	Last 4 Digits of SSN*:			
	<input type="checkbox"/> Member information below is the same as Patient			
	Date of Birth*: (mm/dd/yyyy)	Gender*:	<input type="radio"/> Male	<input type="radio"/> Female
	Last Name*:	First Name*:	MI:	
	Address 1*:	Address 2:		
City*:	State*:	ZIP Code*:	ZIP+4:	

CLAIM	Date of Service*: (mm/dd/yyyy)	<input type="checkbox"/> 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.....	\$	<input type="radio"/> Single	<input type="radio"/> Progressive
	Lens.....	\$	<input type="radio"/> Bi-focal	<input type="radio"/> Lenticular
	Lens tints or coatings.....	\$	<input type="radio"/> Tri-focal	
	Contact Lens Exam / Fitting Evaluation.....	\$		
	Contacts.....	\$		

PROVIDER	Last Name:	First Name:	
	Office Name:		
	Address 1*:	Address 2:	
	City*:	State*:	ZIP Code*:

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: _____