

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 35238-0518

Ref # _____

Member Information

Policyholder/Employee 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)

Exam \$ _____ . _____	Lens Type: (Choose One) Single <input type="checkbox"/> Progressive <input type="checkbox"/> Bi-focal <input type="checkbox"/> Lenticular <input type="checkbox"/> Tri-focal <input type="checkbox"/> Contacts <input type="checkbox"/>	Date services were received: ____/____/____
Frame \$ _____ . _____		Check here if another insurance company has made payment to you, another insurer or the doctor's office. <input type="checkbox"/>
Lens \$ _____ . _____		If so, attach a copy of the statement showing payment.
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 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: ____/____/____