vsp vision care

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 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: _____

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