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 35238-5018

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 $.

Frame $.

Lens $.

Lens tints or coatings $.

Contacts $.

Total Paid $.
(Do not add tax or shipping)

Lens Type: (Choose One)

Single Progressive

Bi-focal Lenticular

Tri-focal Contacts

Date services were received ___/___/____

Check here if another insurance company has made payment to you, another insurer or the doctor's office.

If so, attach a copy of the statement showing payment.

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: ____/____/_____