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

Member's ID or Last 4 Digits of SSN _____ Date of Birth ___/___/_____

First Name _____ Last Name _____

Address _____ Apt _____

City _____ State _____ Zip _____

(___) _____ _____ Employer / Group _____

Daytime Phone #

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 my eyecare and/or eyewear satisfaction. I also attest that the information I have provided above is complete and accurate.

I fully understand and consent to the above statement: _____ Date: _____

For your protection state law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment is subject to criminal and civil penalties.