REQUEST FOR REIMBURSEMENT

Saw an out-of-network doctor? We are here to help. If you have out-of-network benefits, these are your options:

Online	OR	By Mail
It's the way to go. It's secure, you can check on claim status, get paid faster, and save on paper. Click the button below or go to www.vsp.com to log into your account and complete an Internet form. You can also create an account there if you don't have one yet. I want to get paid faster		Still want to mail the form in? Follow the form instructions on the next page.

Tips to speed claims processing:

Missing or incomplete information will slow down claims processing. Be reimbursement ready by making sure the following are done:

- Copy of itemized receipts or service statements that contain the following:
  - Doctor's name or office name
  - Name of patient
  - Date of service
  - Each service received and the amount paid
- You typically have 12 months from the date of service to submit for reimbursement.
- Make sure all required fields have a value and dates are in the following format: Month/Day/Four-Digit Year.

Why stay in-network next time? Here are some benefits to staying in-network:

SAVE MONEY. Get the coverage you deserve at low out-of-pocket costs.

SAVE TIME. With more than 37,000 in-network doctors to choose from, it's easy to find one who's conveniently located near your work or home.

SAVE THE HASSLE. There are no claim forms to fill out when you see an in-network doctor. Your VSP network doctor and VSP will take care of it for you.

FORM INSTRUCTIONS

The form must be filled out by the member. All fields flagged with an asterisk (*) are required. The form is fillable, so you do not have to hand write. Fill it out on a computer, print it, and mail it in. If you decide to hand write, use blue or black ink.

Patient section:

1. Select the patient's relation to the member. Choose only one.
2. Enter the patient's date of birth in the following format: Month/Day/Four-Digit Year
3. Select a gender. Choose only one.
4. Enter the patient's last name and first name.
5. Enter the address, city, state and ZIP code.
6. The patient's middle initial and ZIP+4 are optional.

Member section:

1. Enter the Last 4 Digits of the member's SSN.
2. If the patient is the member, select "Member information below is the same as Patient."
3. Otherwise, enter the member's information:
    a. Enter the member's date of birth in the following format: Month/Day/Four-Digit Year
    b. Select a gender. Choose only one.
    c. Enter the member's last name and first name.
    d. Enter the first address line, city, state, and ZIP code.
    e. The member's middle initial, second address line, and ZIP+4 are optional.

Claim section:

1. Enter the Date of Service in the following format: Month/Day/4-Digit Year.
2. Enter the amount charged for each applicable line item. Ensure they match the receipts.
3. Select a Lens Type.
4. If another insurance company is involved, check the box and attach a copy of the statement showing payment.

Provider section:

1. If the provider's name is known, enter the provider's last name and first name.
2. If the office name is known, enter the provider's office name.
3. Step #1 or #2 or both must contain a value.
4. Enter the first address line, city, state, and ZIP code.
5. The second address line and ZIP+4 are optional.

Print and Sign section:

1. Review the completed form for accuracy.
2. Read the acknowledgement paragraph.
3. Print the form.
4. Sign the form.
5. Date the form in the following format: Month/Day/Four-Digit Year.
6. Only the form on the next page needs to be mailed in. All other pages are for reference.

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 385018
Birmingham, AL 35238-5018

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: _____