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 997105
Sacramento, CA 95899-7105

Ref #

Member Information

Member's 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 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: _____