Out-Of-Network Reimbursement Form

Member Information:

Member's ID or Social Security Number:_____

Member's Name:_____ **Date of Birth:**_____

Address:_____ **E-Mail Address:**_____

City:_____ **State:**_____ **ZIP Code:**_____ **Phone Number:**_____

Name of Group/Employer:_____

Patient Information:

Patient's Name:_____ **Date of Birth:**_____

Relationship to Member:_____

If the patient is a child (and over the age of 18):

Is the child a full time student? Y/N **Name of School:**_____

Is the child physically impaired? Y/N

Reimbursement Request Information:

Date Services were received:_____

Services received (please circle any that apply and provide the amount paid for each)

Exam **$**_____

Lenses: Single Vision
Bifocal
Trifocal **$**_____
Progressive
Lenticular

Lens Options:
Tint **$**_____

*Other **$**_____
*(Includes Scratch Coatings, Anti-Reflective coatings, etc.)

Frame **$**_____

Contact Lenses **$**_____

Contact fitting &/or Evaluation **$**_____

Provider/Optical Shop Name: Lens.com, Inc. **Phone Number:** (800) 536-7266

Address: 3016 Georgia St.

City: Louisiana **State:** MO **ZIP Code:** 63353

Submit this form along with related receipts to:
VSP; Att: Claim Services;
PO Box 385018; Birmingham, AL 35238-5018

For additional information on your eyecare benefits, please visit our website at: VSP.com