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: _____