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.

Vision Service Plan
Attn: Claims Services
P. O. 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

( ) 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: _____