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 385018
Birmingham, AL 35238-0518

Ref #

Member Information

Policyholder/Employee 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 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: ___/___/____

VSP Vision care for life is a registered trademark of Vision Service Plan.