

REQUEST FOR REIMBURSEMENT

Saw an out-of-network doctor? We are here to help. If you have out-of-network benefits, these are your options:

Online

It's the way to go. It's secure, you can check on claim status, get paid faster, and save on paper. Click the button below or go to www.vsp.com to log into your account and complete an Internet form. You can also create an account there if you don't have one yet.

I want to get paid faster

OR

By Mail




Still want to mail the form in? Follow the form instructions on the next page.

Tips to speed claims processing:

Missing or incomplete information will slow down claims processing. Be reimbursement ready by making sure the following are done:

- Copy of itemized receipts or service statements that contain the following:
 - Doctor's name or office name
 - Name of patient
 - Date of service
 - Each service received and the amount paid
- You have 180 days from the date of service to submit for reimbursement.
- Make sure all required fields have a value and dates are in the following format: Month/Day/Four-Digit Year.

Why stay in-network next time? Here are some benefits to staying in-network:

-  **SAVE MONEY.** Get the coverage you deserve at low out-of-pocket costs.
-  **SAVE TIME.** With more than 37,000 in-network doctors to choose from, it's easy to find one who's conveniently located near your work or home.
-  **SAVE THE HASSLE.** There are no claim forms to fill out when you see an in-network doctor. Your VSP network doctor and VSP will take care of it for you.

VSP MEMBER REIMBURSEMENT FORM

To request reimbursement, complete and print this form, 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 35238-5018

PATIENT	Relation to Member*: (choose one)			
	<input type="checkbox"/> Member	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Dependent Parent	<input type="checkbox"/> Disabled Dependent
	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Full-Time Student	<input type="checkbox"/> Other
	Date of Birth*: (mm/dd/yyyy)		Gender*:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Last Name*:		First Name*:	MI:
	Address*:			
City*:	State*:	ZIP Code*:	ZIP+4:	

MEMBER	Last 4 Digits of SSN*:			
	<input type="checkbox"/> Member information below is the same as Patient			
	Date of Birth*: (mm/dd/yyyy)		Gender*:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Last Name*:		First Name*:	MI:
	Address 1*:		Address 2:	
	City*:	State*:	ZIP Code*:	ZIP+4:

CLAIM	Date of Service*: (mm/dd/yyyy)		<input type="checkbox"/> Another insurance company made payments to you, another insurer, or the doctor's office. If so, attach a copy of the statement showing payment.	
	Exam.....	\$	Lens Type*: (choose one) <input type="checkbox"/> Single <input type="checkbox"/> Progressive <input type="checkbox"/> Bi-focal <input type="checkbox"/> Lenticular <input type="checkbox"/> Tri-focal	
	Frame.....	\$		
	Lens.....	\$		
	Lens tints or coatings.....	\$		
	Contact Lens Exam / Fitting Evaluation.....	\$		
	Contacts.....	\$		

PROVIDER	Last Name:		First Name:	
	Office Name:			
	Address 1*:		Address 2:	
	City*:	State*:	ZIP Code*:	ZIP+4:

PRINT & SIGN	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: _____

FORM INSTRUCTIONS

The form must be filled out by the member. All fields flagged with an asterisk (*) are required. The form is fillable, so you do not have to hand write. Fill it out on a computer, print it, and mail it in. If you decide to hand write, use blue or black ink.

Patient section:

1. Select the patient's relation to the member. Choose only one.
2. Enter the patient's date of birth in the following format: Month/Day/Four-Digit Year
3. Select a gender. Choose only one.
4. Enter the patient's last name and first name.
5. Enter the address, city, state and ZIP code.
6. The patient's middle initial and ZIP+4 are optional.

Member section:

1. Enter the Last 4 Digits of the member's SSN.
2. If the patient is the member, select "Member information below is the same as Patient."
3. Otherwise, enter the member's information:
 - a. Enter the member's date of birth in the following format: Month/Day/Four-Digit Year
 - b. Select a gender. Choose only one.
 - c. Enter the member's last name and first name.
 - d. Enter the first address line, city, state, and ZIP code.
 - e. The member's middle initial, second address line, and ZIP+4 are optional.

Claim section:

1. Enter the Date of Service in the following format: Month/Day/4-Digit Year.
2. Enter the amount charged for each applicable line item. Ensure they match the receipts.
3. Select a Lens Type.
4. If another insurance company is involved, check the box and attach a copy of the statement showing payment.

Provider section:

1. If the provider's name is known, enter the provider's last name and first name.
2. If the office name is known, enter the provider's office name.
3. Step #1 or #2 or both must contain a value.
4. Enter the first address line, city, state, and ZIP code.
5. The second address line and ZIP+4 are optional.

Print and Sign section:

1. Review the completed form for accuracy.
2. Read the acknowledgement paragraph.
3. Print the form.
4. Sign the form.
5. Date the form in the following format: Month/Day/Four-Digit Year.
6. Only the form on the next page needs to be mailed in. All other pages are for reference.

FRAUD WARNINGS

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Language Assistance Services Available

English: ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-877-7195 (TTY: 1-800-428-4833).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-877-7195 (TTY: 1-800-428-4833).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-877-7195 (TTY: 1-800-428-4833)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-877-7195 (TTY: 1-800-428-4833).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-877-7195 (TTY: 1-800-428-4833) 번으로 전화해 주십시오.

Tagalog –Filipino: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-877-7195 (TTY:1-800-428-4833).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-877-7195 (телетайп: 1-800-428-4833).

Armenian: Ուշադրություն: Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք 1-800-877-7195 (TTY (հեռատիպ) 1-800-428-4833)։

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-877-7195 (ATS : 1-800-428-4833).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-877-7195 (TTY: 1-800-428-4833)まで、お電話にてご連絡ください。

Tongan: FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-800-877-7195 (TTY: 1-800-428-4833).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-877-7195 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-428-4833).

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, បេសវាជំនួយខ្លឹមសារ បរិយមិត្តភាសាខ្មែរ គឺអនុញ្ញាតឱ្យអ្នកប្រើប្រាស់សេរី ឱ្យបានឥតគិតថ្លៃ 1-800-877-7195 (TTY: 1-800-428-4833)។

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-877-7195 (TTY: 1-800-428-4833) 'ਤੇ ਕਾਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-877-7195 (TTY: 1-800-428-4833).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚክተሎ ቁጥር ይደውሉ 1-800-877-7195 (መስማት ለተሳናቸው: 1-800-428-4833)።

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-877-7195 (телетайп: 1-800-428-4833).

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-877-7195 (टिपिवाइ: 1-800-428-4833) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-877-7195 (TTY: 1-800-428-4833).

Sudan (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-877-7195 (TTY: 1-800-428-4833).

Thai: เรขณ: ถาคณพคภาษาไทยคณสามารถไขบรการชวยเหลือทางภาษาไดพร โทร 1-800-877-7195 (TTY: 1-800-428-4833).

Laotian: ໂປດຊາບ: ຖາວາ ທານເວາພາສາ ລາວ, ການບລການຊວຍເຫອດານພາສາ, ໂດຍບເສງຄາ, ແມນມພອມໃຫທານ. ໂທຣ 1-800-877-7195 (TTY: 1-800-428-4833).

Cushite/Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-877-7195 (TTY: 1-800-428-4833).

Persian (Farsi):

مه‌ارف ام‌ش (ی‌ارب ن‌اگوار ت‌روصب ی‌زابز ت‌لاه‌ست، د‌یزک یم وگ‌نگ‌س‌ران ن‌ابز ه‌ب رگا: ه‌جوت اب .دش‌اب یم (TTY: 800-428-4833-1) د‌یزگ‌ب س‌ام‌ 1-800-877-7195.

Arabic:

مؤر) 1-800-877-7195 مؤرب لصنا .ن اجملاب لكل رفاوتنا ةبوغللا ةدعاسملا تامدخ ناك، ةغللا ركذا ثدحت تنك اذا: ةظوحلم مكبللاو مصلا فتاه: 1-800-428-4833.)

Navajo

Díí baa akó nínízin: Díí saad bee yánílti’go Diné Bizaad, saad bee áká’ánída’áwo’déé’, t’áá jiik’eh, éí ná hóló, kojí’ hódíílnih 1-800-877-7195 (TTY: 1-800-428-4833.)

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-877-7195 (TTY: 1-800-428-4833) पर कॉल करें।