Request for Reimbursement

vsp vision care

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

ONLINE

The way to go. It's secure, you can check claim status, get paid faster, and save on paper. Click the button below or go to **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:

Please attach a readable copy of itemized receipts, invoices or service statements that contain all of the following information:

- Name of provider (ex. doctor, office, website, or retailer)
- Name of patient
- Date service was received (ex. date of exam or date glasses were ordered)
- Complete description and amount paid for each service

- You typically have 12 months 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.
- If you have Laser Vision coverage and are submitting for reimbursement:
  - The itemized receipt and/or letter from your provider must contain the following information:
    - Which eye(s) received the surgery
    - Surgeon Name
    - Facility Name
    - Surgery DOS
    - Type of procedure (e.g. PRK, LASIK, Custom LASIK and Custom PRK)
    - Cost of procedure
    - Member's name
    - Member's ID number (This may be the member's SSN or member's unique ID number)
    - Member's mailing address
    - Patient's name
    - Patient's DOB
    - Patient's relationship to the member (e.g. member, spouse, child, etc.)
    - Name of client who provides the VSP coverage (client name)
- Please note: Laser Vision warranty enhancements are not reimbursable under Laser Vision Care out-of-network. Claims may only be submitted for surgery (one or both eyes) and/or pre/post-operative care.
- Write the amount of the Laser Vision Care claim under "Exam" on the reimbursement form.

Form Instructions

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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 handwrite. Fill out on a computer, print, and mail in. If you decide to handwrite, 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 four digits of the member's SSN or member's unique ID number.
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/Four-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 acknowledgment 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.

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 495918
Cincinnati, OH 45249-5918

PATIENT

Relation to Member*: *(choose one)*

☐ Member ☐ Domestic Partner ☐ Dependent Parent ☐ Disabled Dependent
☐ Spouse ☐ Child ☐ Full-Time Student ☐ Other

Date of Birth*: *(mm/ddyyyy)* _____ Gender*: ☐ Male ☐ Female

Last Name*:_____ First Name*:_____ MI:____

Address*:_____

City*:_____ State*:_____ ZIP*:_____ ZIP+4:_____

MEMBER

Last Four Digits of SSN or Unique ID*: _____

☐ Member information below is the same as Patient

Date of Birth*: *(mm/dd/yyyy)* _____ Gender*: ☐ Male ☐ Female

Last Name*:_____ First Name*:_____ MI:____

Address 1*:_____ Address 2:_____

City*:_____ State*:_____ ZIP*:_____ ZIP+4:_____

CLAIM

Date of Service*: *(mm/dd/yyyy)* _____

☐ 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..... $
Frame..... $
Lens..... $
Lens Tints or Coatings..... $
Contact Lens Exam/Fitting Evaluation..... $
Contacts..... $

Lens Type*: *(choose one)*
☐ Single
☐ Bifocal
☐ Trifocal
☐ Progressive
☐ Lenticular

PROVIDER

Last Name:_____ First Name:_____

Office Name:_____

Address 1*:_____ Address 2:_____

City*:_____ State*:_____ ZIP*:_____ ZIP+4:_____

PRINT AND 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:_____