



Out-Of-Network Reimbursement Form

Member Information

member's name _____ date of birth _____
address _____
city _____ state _____ ZIP _____
member's ID # (see below) _____

Active/LTD/Pensioner = 6 digit State ID & last four of ssn

Surviving Spouse = 6 digit State ID, S01 & last four of ssn

Cobra = last four of ssn

name of employer ____ State of Delaware 12260523 or State of Delaware Pensioners 30012869__

Patient Information

patient's name _____ date of birth _____

relationship to member _____

if the patient is a child (and over the age of 18):

Is the child a full time student? [yes] [no] name of school _____

Is the child physically impaired? [yes] [no]

Reimbursement Request Information

date services were received _____

services received (circle any that apply and provide the amount paid for each)

exam \$ _____

lenses single vision

bifocal

trifocal \$ _____

progressive

lenticular

lens options

tint \$ _____

other* \$ _____

*(includes scratch coatings, anti-reflective coatings, etc.)

frame \$ _____

contact lenses \$ _____

contact fitting &/or evaluation \$ _____

provider/optical shop _____ phone _____

address _____

city _____ state _____ ZIP _____

Coordination of Benefits Information

If you are coordinating benefits with another insurance carrier, we need a complete copy of the Explanation of Benefits from your primary insurance carrier. The Explanation of Benefits must indicate the service(s) which were received, as well as the amount paid, denied, or applied to your deductible. This information can be obtained from the provider who performed your recent services.

Submit this form along with related receipts within six months of the claim to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105