Blue Vision

Out-of-Network Claim Reimbursement

You are encouraged to seek eye care from an in-network Blue Vision provider, administered by VSP.

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 network doctor and Blue Vision will take care of it for you.

If you do see care from a provider that is out-of-network, you may have benefits available and can seek reimbursement for your claim by completing the form on page 2. All fields flagged with an asterisk (*) are required. Complete form on your computer, print, and mail it in. If you decide to handwrite, use blue or black ink.

Once form is complete and printed, please enclose a legible copy of your itemized receipt(s), and send them to:

VSP
P.O. Box 495918
Cincinnati, OH 45249-5918

Be sure to keep a copy of your form, receipts, and statements for your records.

vsp vision care

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/dd/yyyy)*		Gender*:	◯ Male ◯ Female				
Last Name*:		First Name*:		MI:			
Address*:							
City*:		State*:		ZIP Code*:		ZIP+4:	

MEMBER

Last 4 Digits of SSN*:							
☐ 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 Code*:		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 ◯ Progressive
◯ Bi-focal ◯ Lenticular
◯ Tri-focal

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: _____