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

vsp vision care

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:_____

Fraud Warnings

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly presents false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana, and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Maine, Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim

Fraud Warnings (Cont.)

containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false or fraudulent claim for penalty of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

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

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: Զանգահարեք **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: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vambesplatno. Nazovite **1.800.877.7195 (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 1.800.428.4833).**

Cambodian: ប្ រយ័ត្ៈ ៖ បរ រ ើស្ នជាអ្ កន្ យាយ ភ្ ស្ ខ្ មរ, បសវ់ាជ៉នយខ្ នកភាសា បរ្ យម នត្ តឈ្ ល គឺអ្ ចម្ នសំរារ់រំប រអ្ ក។ ចរ ទរស្ត្ំព **1.800.877.7195 (TTY: 1.800.428.4833)**។

Punjabi: ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸੀ ਪੰਜਾਬੀ ਬੋਲੋਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧ ਿੱਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇਲਈ ਮੁਫਤ ਉਪਲਬਾਿ ਹੈ। **1.800.877.7195 (TTY: 1.800.428.4833)** 'ਤੇਕਾਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche

Language Assistance Services (Cont.)

Hilfsdienstleistungen zur Verfügung. Rufnummer: **1.800.877.7195 (TTY: 1.800.428.4833)**.

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው 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 दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको दनदतत भाषा सहायतता सेवाहरू दनःशिुल्क रूपमा उपलब्ध छ । फोन गनुहोस् **1.800.877.7195 (ददिविार्इ: 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: เรยน: ถาคณพดภาษาไทยคณสามารถใชบรการชวยเหลอทางภาษาไดฟร โทร **1.800.877.7195 (TTY: 1.800.428.4833)**.

Laotian: ໂປດຊາບ: ຖາວາ ທານເວາພາສາ ລາວ, ການບລການຊວຍເຫອດານພາສາ, ໂດຍບເສບຄາ, 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):

Arabic: [illegible] **TTY: 1.800.428.4833** [illegible] **1.800.877.7195**.

Navajo: [illegible] **1.800.877.7195** [illegible] **1.800.428.4833** .)

हिंदी **(Hindi):**
ध्यानदें: यददआप बोलते हैं तो आपके ललए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1.800.877.7195 (TTY: 1.800.428.4833)** पर कॉल करें।

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

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Classification: Confidential