

## REQUEST FOR REIMBURSEMENT

Saw an out-of-network doctor? We are here to help. If you have out-of-network benefits, you can send us a completed form online or by mail:

### Online

It's the way to go. It's secure, you can check on your status, you get paid faster and you just saved on paper. Click the button below or go to [www.vsp.com](http://www.vsp.com) to log into your account and complete an online form. You can also create an account there.

I want to get paid faster

### 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 include the following information printed on them:
  - Doctor's name or office name
  - Name of patient
  - Date of service
  - Each service received and the amount paid
- 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.

### 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.

### By Mail

Still want to mail the form in? No problem. Complete and mail the attached form to:

VSP  
PO Box 385018  
Birmingham, AL 35238-5018

Here are the form instructions:

The form should be filled out by the member. All fields flagged with an asterisk (\*) are required. The form is fillable meaning you don't have to hand write all the information. Just fill it out on a computer, print it, and mail it in. If you decide to manually enter, please use blue or black ink.

Patient section:

1. Select the patient's relation to the member. Choose only one.
2. If dependent, select one of the following: Spouse, Partner, Full-Time Student, Child, or Disabled Dependent.
3. Enter the patient's date of birth in the following format: MM/DD/YYYY
4. Select a gender. Choose only one.
5. Enter the patient's last name.

6. Enter the patient's first name.
7. The patient's middle initial is optional.
8. Enter the address line.
9. Enter the city.
10. Enter the state.
11. Enter the zip code.

Member section:

1. Enter the Last 4 Digits of the member's SSN.
2. If the patient is the member, select "Same as Patient."
3. Otherwise, enter the member's information:
  - a. Enter the member's date of birth in the following format: MM/DD/YYYY
  - b. Select a gender. Choose only one.
  - c. Enter the member's last name.
  - d. Enter the member's first name.
  - e. The member's middle initial is optional.
  - f. Enter the first line address.
  - g. The second line address is optional.
  - h. Enter the city.
  - i. Enter the state.
  - j. Enter the zip code.

Claim section:

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

Provider section:

1. If the provider's name is known:
  - a. Enter the provider's last name.
  - b. Enter the provider's first name.
2. If the office name is known:
  - a. Enter the provider's office name.
3. Either #1 or #2 or both must contain a value.
4. Enter the first line address.
5. The second line address is optional.
6. Enter the city.
7. Enter the state.
8. Enter the zip code.

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: MM/DD/YYYY.
6. Only the form on the next page needs to be mailed in. All other pages are for your 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 385018  
 Birmingham, AL 35238-5018

<b>PATIENT</b>	Relation to Member*: <i>(choose one)</i>			
	<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"/> F/T Student	<input type="checkbox"/> Other
	Date of Birth*: <i>(mm/dd/yyyy)</i>	Gender*:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
	Last Name*:	First Name*:	MI:	
	Address*:			
City*:	State*:	Zip Code*:		

<b>MEMBER</b>	Last 4 Digits of SSN*:		
	<input type="checkbox"/> Same as Patient		
	Date of Birth*: <i>(mm/dd/yyyy)</i>	Gender*:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Last Name*:	First Name*:	MI:
	Address 1*:	Address 2:	
	City*:	State*:	Zip Code*:

<b>CLAIM</b>	Date of Service*: <i>(mm/dd/yyyy)</i>	<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*: <i>(choose one)</i>
	Frame .....	\$	<input type="checkbox"/> Single <input type="checkbox"/> Progressive
	Lens.....	\$	<input type="checkbox"/> Bi-focal <input type="checkbox"/> Lenticular
	Lens tints or coatings .....	\$	<input type="checkbox"/> Tri-focal
	Contact Lens Exam / Fitting Evaluation.....	\$	
	Contacts.....	\$	

<b>PROVIDER</b>	Last Name:	First Name:
	Office Name:	
	Address 1*:	Address 2:
	City*:	State*:

<b>PRINT &amp; SIGN</b>	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 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 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: Ջանգահարեք 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 ៖ ប្រសិនបើ អ្នកនិយាយភាសាខ្មែរ, ប្រសិនបើ អ្នកមានបញ្ហាសម្រាប់ ការស្តាប់ ឬ ការនិយាយ, យើងមានសេវាជំនួយភាសាសេរីយ៍ ឲ្យអ្នកប្រើប្រាស់បានឥតគិតថ្លៃ។ ទូរស័ព្ទ 1-800-877-7195 (TTY: 1-800-428-4833)។

Punjabi: ਧਿਆਨ ਧਾਰਿ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1800877-7195 (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 ሊያግዝዎት ተዘጋጅተዋል። 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 ो त े ुन्छ ो दनदतत भाषा क रूपमा उपलब्ध छ । फोन दिनेह स पार नेपाल भने सहायता सेवामाहरु गनुहोस ।  
: इल ी तपाइक दनिश्ल  
बोलन्ह

1-800-877-7195 (दिदिवाई: 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: ถาคณพตภาษาไทยคณสามารถใชขบรการชวยเหลือทางภาษาไดฟรี โทร 1-800-877-7195 (TTY: 1-800-428-4833).

Laotian: ໂປດຊາບ: ຖ້າວາ ທານວອາພາສາ ລາວ, ການບລການຊວຍເຫອດານພາສາ, ໂດຍບເສງຄາ, ແມນມພອມໄຫທານ. 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):

مصارف امش ی ارب ن اگهار تروص ب ی زابز نال و هس، دیزک یم وگنگ یران ن ابز هب رگا: هجوت  
دشاب یم (TTY: 800-428-4833-1) دیرگب س ام 1-7195-877-800-1  
اب

Arabic: تظوحلم:

ناجى الب.  
كفال رفاوتنا

لصنا  
مؤرب  
7195-  
877-  
800-1(  
مؤر

مكبل او مصال فتاه: 800-428-4833-1.)

## Navajo

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá  
jiiik'eh, éí ná hóló, koji' hódíłnih 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।