VSP Out-of-Network Reimbursement Form

Employer: California State University **Group Plan Number: 12292796**

Employee Information:

Employee's Name: _____ **Date of Birth:** _____

Last 4-digits of Employee's Social Security Number: _____ **Campus of Employment:** _____

Mailing Address: _____ **City:** _____ **State:** ____ **ZIP Code:** _____

Phone #: _____

Patient Information:

Patient's Name: _____ **Date of Birth:** _____

Relationship to Employee: _____

Reimbursement Request Information:

Date Services were received: _____

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

Exam $_____

Lenses: Single Vision
Bifocal
Trifocal $_____

Lens Options:

Tint $_____

Other* $_____
*(Includes Scratch Coatings, Anti-Reflective coatings, etc.)

Frame $_____

Contact Lenses $_____

Contact fitting &/or Evaluation $_____

If available, provide the following information about the out-of-network doctor where services were rendered:

Provider Name: _____ **Phone Number:** _____

Address: _____

City: _____ **State:** ____ **ZIP Code:** _____

Instructions for Reimbursement:

Attach a copy of the itemized receipt to this form and mail to the address below. For employees eligible for the Video Display Terminal (VDT) coverage, you must also obtain the VSP VDT Confirmation Form from the campus Benefits Office and include it with the paperwork in order to be reimbursed according to the CSU plan allowances.

VSP
P.O. Box 997105
Sacramento, CA 95899-7105
Attn: Out-of-Network Claims

For additional information on your eyecare benefits, please visit vsp.com or call 800-877-7195.