

# Complete this form and attach receipts for Non-Panel Provider reimbursement

Member's name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Member's Social Security number \_\_\_\_\_ School district \_\_\_\_\_

Patient's name and relationship to member \_\_\_\_\_

Patient's birth date \_\_\_\_\_



*Your provider's receipt must provide a breakdown of charges (exam, lenses, frames and additional materials). If it does not, complete this section to show the breakdown. A "total" figure does not provide adequate information for payment by VSP.*

**Date of service for:** exam \_\_\_\_\_  
 lenses \_\_\_\_\_  
 frames \_\_\_\_\_  
 contacts \_\_\_\_\_

Cost of exam \$ \_\_\_\_\_

Vision exam performed by an:

Please check appropriate box:

Optometrist (OD)

Ophthalmologist (MD)

**Type of lens:** contacts   
 single vision   
 bi-focal   
 tri-focal   
 lenticular   
 other (specify)  \_\_\_\_\_

Cost of contacts \$ \_\_\_\_\_  
 Cost of lens \$ \_\_\_\_\_  
 Cost of lens \$ \_\_\_\_\_  
 Cost of lens \$ \_\_\_\_\_  
 Cost of lens \$ \_\_\_\_\_  
 Cost of lens \$ \_\_\_\_\_

**Frame:** \_\_\_\_\_ Cost of frame \$ \_\_\_\_\_

**Additional materials and charges:**  tint  
 Polaroid lens  
 Other (specify) \_\_\_\_\_

Cost of tint \$ \_\_\_\_\_  
 Cost of Polaroid \$ \_\_\_\_\_  
 Cost \$ \_\_\_\_\_

Mail completed form and receipts to:

**VISION SERVICE PLAN**  
 P.O. Box 997105  
 Sacramento, CA 95899-7105  
 Call toll-free 800.877.7195



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