Out-Of-Network Claim Reimbursement Form

Member Information:

Member's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: ___ ZIP Code: _____

Member's ID (Blue Cross ID #): _____

VSP Account Number:12193879

Patient Information:

Patient's Name: _____ Date of Birth: _____

Relationship to Member: _____

If the patient is a child over the Plan's age limit:

Is the child a full time student? Y ☐ N ☐ Name of School: _____

Is the child physically impaired? Y ☐ N ☐

Reimbursement Request Information:

Date Services were received: _____

Other* $_____

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

Frame $_____

Contact Lenses $_____

Contact fitting &/or Evaluation $_____

tical Shop Name: _____ Phone Number: _____

_____

_____ State: ___ ZIP Code: _____