

## VSP Out-of-Network Reimbursement Form

Last 4-digits of Employee's Social Security Number	r: Campus of	Employment:
Mailing Address:	City:	State:ZIP Code:
Phone #:		
Patient Information:		
Patient's Name:	Date of Bi	rth:
Relationship to Employee:		
<b>Reimbursement Request Information:</b>		
Date Services were received:		
Services received (please circle any that apply and p	provide the amount pai	id for each)
Exam	\$	
<b>Lenses:</b> Single Vision Bifocal Trifocal	\$	
Lens Options:		
- Tint	\$	
Other* *(Includes Scratch Co	\$ atings, Anti-Reflective o	patings, etc.)
Frame	\$	
Contact Lenses	\$	
Contact fitting &/ or Evaluation	\$	
If available, provide the following information abou	ıt the out-of-network d	octor where services were rendered:
Provider Name:		umber:
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.