



## 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](http://vsp.com) or call 800-877-7195.*