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:	
	$_____
Lens Options:	
	$_____
	$_____
Frame	**$**
Contact Lenses	**$**
	$

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.