

VISION SERVICE PLAN

NON-MEMBER DOCTOR CLAIM FORM

If you have obtained vision care services from a non-member doctor and would like to submit a claim to VSP for reimbursement, please complete the following:

Group Name:	BP
Employee Name:	
Employee Social Security #:	
Patient's Name:	
Patient's Date of Birth:	
Mailing Address:	
Street:	_____
City/State/Zip:	_____ / ____ / _____

Please attach itemized receipts that include the separate cost of the examination, lenses, frame or contact lenses and mail to:

**Vision Service Plan
P. O. Box 997100
Sacramento, CA 95899-7100
Attn: Non-Member Claims
(800) 877-7195**

