

Complete this form and attach receipts for Non-Panel Provider reimbursement

Member's name _____

Address _____

City _____ State _____ Zip _____

Member's Social Security number _____ School district _____

Patient's name and relationship to member _____

Patient's birth date _____



Your provider's receipt must provide a breakdown of charges (exam, lenses, frames and additional materials). If it does not, complete this section to show the breakdown. A "total" figure does not provide adequate information for payment by VSP.

Date of service for: exam _____ lenses _____ frames _____ contacts _____	Cost of exam \$ _____ Vision exam performed by an: <small>Please check appropriate box:</small> <input type="checkbox"/> Optometrist (OD) <input type="checkbox"/> Ophthalmologist (MD)
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Type of lens: contacts <input type="checkbox"/> single vision <input type="checkbox"/> bi-focal <input type="checkbox"/> tri-focal <input type="checkbox"/> lenticular <input type="checkbox"/> other (specify) <input type="checkbox"/> _____	Cost of contacts \$ _____ Cost of lens \$ _____ Cost of lens \$ _____ Cost of lens \$ _____ Cost of lens \$ _____ Cost of lens \$ _____
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Frame: _____ Cost of frame \$ _____

Additional materials and charges: <input type="checkbox"/> tint <input type="checkbox"/> Polaroid lens <input type="checkbox"/> Other (specify) _____	Cost of tint \$ _____ Cost of Polaroid \$ _____ Cost \$ _____
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Mail completed form and receipts to:

VISION SERVICE PLAN
 P.O. Box 997105
 Sacramento, CA 95899-7105
 Call toll-free 800.877.7195



MESSA

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