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:
Please check appropriate box:
☐ Optometrist (OD)
☐ Ophthalmologist (MD)

Type of lens:

contacts ☐	Cost of contacts	$ _____
single vision ☐	Cost of lens	$ _____
bi-focal ☐	Cost of lens	$ _____
tri-focal ☐	Cost of lens	$ _____
lenticular ☐	Cost of lens	$ _____
other (specify) ☐ _____	Cost of lens	$ _____

Frame: Cost of frame $ _____

Additional materials and charges:

☐ tint	Cost of tint	$ _____
☐ Polaroid lens	Cost of Polaroid	$ _____
☐ Other (specify) _____	Cost	$ _____

Mail completed form and receipts to:

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

MESSA
www.messa.org

1475 Kendale Blvd., P.O. Box 2560 • East Lansing, Michigan 48826-2560
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