

Members

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How to Request Reimbursement

For faster reimbursement, use our convenient submission form for each patient.

- 1) Follow the directions and fill out the form in its entirety.
- 2) When finished, select "Print This Form"
- 3) Complete a form for each dependent and/or plan.
- 4) Verify information on form is correct, attach itemized receipts, and mail form and receipts to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Important: Most out-of-network requests for reimbursement must be submitted to VSP within six months. However, certain allow out-of-network reimbursements to be submitted beyond the six-month timeframe. Please review your group literature information for deadlines and details.

Please complete the information below.

*The following areas are required to complete your request.

Member Information

Member's Name:

Name of Member's Group or Employer
HURON CITY SCHOOL DISTRICT

*Member's Date of Birth:

E-Mail Address:

(mm/dd/yyyy)

*Address:

*City:

*State:

*ZIP Code:

Check this box if foreign address. Type complete mailing address below.

Patient Information

*Patient's Name:

*Patient's Date of Birth:

(mm/dd/yyyy)

*Relation to Member:

*VSP WellVision Coverage:

*Date Services were received:

(mm/dd/yyyy)

Name of School:

Would you like to coordinate your benefits? Yes No

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