

VISION SERVICE PLAN (VSP) OUT-OF-NETWORK CLAIM FORM

INSURED'S NAME	INSURED'S DOB (MM/DD/YY)	INSURED'S ID NUMBER (SS #)
INSURED'S ADDRESS	INSURED'S SEX	PATIENT'S NAME
	M F	
CITY	STATE	PATIENT'S DOB (MM/DD/YY)
ZIP CODE	PHONE NUMBER	PATIENT'S RELATIONSHIP TO INSURED (Circle one)
		SELF SPOUSE CHILD OTHER
EMPLOYER'S NAME	GROUP ID NUMBER	
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		DATE
EYEGASSES	CONTACT LENSES	OTHER
RX	RX	
O.D.	O.D.	
O.S.	O.S.	
ADD	BASE CURVE DIAMETER	
DATE OF SERVICE (MM/DD/YY)		

FOR EYES OPTICAL

 () _____
 Tax ID # _____

**VISION SERVICE PLAN
 ATTN: OUT-OF NETWORK CLAIMS
 P.O. BOX 997105
 SACRAMENTO, CA 95899-7105**