Blue Vision

Out-of-Network Claim Reimbursement

You are encouraged to seek eye care from an in-network Blue Vision provider, administered by VSP.

Here are some benefits to staying in-network:

- **Save money.** Get the coverage you deserve at low out-of-pocket costs.
- **Save time.** With more than 37,000 in-network doctors to choose from, it's easy to find one who's conveniently located near your work or home.
- **Save the hassle.** There are no claim forms to fill out when you see an in-network doctor. Your network doctor and Blue Vision will take care of it for you.

If you do see care from a provider that is out-of-network, you may have benefits available and can seek reimbursement by completing an out of network claim form.

Submission instructions:

1. Login to your member account at **bcbsm.com.** Select *Vision* from the *My Coverage* menu and select *Go to VSP*.
2. Once you on the VSP website, select *Benefits,* then *Oops Out of Network,* then *Submit a Claim* to start a new claim.
3. Or complete the following form on your computer, print, and mail it in. If you decide to handwrite, use blue or black ink. Once form is complete and printed, please enclose a legible copy of your itemized receipt(s), and send to:

   VSP
   P.O. Box 495918
   Cincinnati, OH 45249-5918

Be sure to keep a copy of your form, receipts, and statements for your records.

vsp vision care

VSP MEMBER REIMBURSEMENT FORM

To request reimbursement, complete and print this form, enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.

VSP
PO Box 495918
Cincinnati, OH 45249-5918

PATIENT

Relation to Member*: *(choose one)*

◯ Member ◯ Domestic Partner ◯ Dependent Parent ◯ Disabled Dependent
◯ Spouse ◯ Child ◯ Full-Time Student ◯ Other

Date of Birth*: *(mm/dd/yyyy)*		Gender*:	◯ Male ◯ Female				
Last Name*:		First Name*:		MI:			
Address*:							
City*:		State*:		ZIP Code*:		ZIP+4:	

MEMBER

Last 4 Digits of SSN*:							
☐ Member information below is the same as Patient							
Date of Birth*: *(mm/dd/yyyy)*		Gender*:	◯ Male ◯ Female				
Last Name*:		First Name*:		MI:			
Address 1*:		Address 2:					
City*:		State*:		ZIP Code*:		ZIP+4:	

CLAIM

Date of Service*: *(mm/dd/yyyy)* _____

☐ Another insurance company made payments to you, another insurer, or the doctor's office. If so, attach a copy of the statement showing payment.

Exam.....	$
Frame.....	$
Lens	$
Lens tints or coatings.....	$
Contact Lens Exam / Fitting Evaluation.....	$
Contacts.....	$

Lens Type*: *(choose one)*

◯ Single ◯ Progressive
◯ Bi-focal ◯ Lenticular
◯ Tri-focal

PROVIDER

Last Name:		First Name:					
Office Name:							
Address 1*:		Address 2:					
City*:		State*:		ZIP Code*:		ZIP+4:	

PRINT & SIGN

I acknowledge that the above-named provider is not a VSP Preferred Provider and that VSP cannot guarantee eye care and/or eyewear satisfaction. By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information I have provided above is complete and accurate.

Claimant Signature: _____ Date: _____