



Out-of-network Reimbursement Form

Prior to printing this form, please verify that the member/dependent is eligible for services either by visiting www.vbaplans.com or by calling VBA's Customer Care Center at 1-800-432-4966. If the patient is not eligible for services, NO payment will be processed.

ALL INFORMATION MUST BE COMPLETED ON THIS FORM

INSTRUCTIONS

- Policyholder completes ALL parts of this form. Please complete all **before** printing this form.
- A separate Reimbursement Form is required for each family member.
- Please attach all itemized receipts to this form. Please be certain that your itemized receipts match the information entered below.
- Mail or fax completed forms to VBA at the address listed below within 90 days of the Date of Service.
- All reimbursements will be sent to the policyholder's address on file. **(Policyholder is responsible for updating address changes with employer.)**

PART 1: TO BE COMPLETED BY POLICYHOLDER (Please complete PART 1 before printing this form.)

POLICYHOLDER FULL NAME		LAST 4 DIGITS OF SSN #	WORK PHONE #	HOME PHONE #
HOME ADDRESS		CITY, STATE, ZIP CODE		EMPLOYER NAME
MEMBER'S (PATIENT) FULL NAME	RELATIONSHIP TO POLICYHOLDER	POLICYHOLDER DATE OF BIRTH	MEMBER DATE OF BIRTH	
My signature certifies this claim is NOT related to occupational accident/injury and I authorize VBA to disclose any necessary information concerning this claim.				
POLICYHOLDER/MEMBER SIGNATURE				DATE

PART 2: USE A SEPARATE FORM FOR EACH FAMILY MEMBER

EXAM	PRACTICE NAME		OD	MD	EXAM FEE
	ADDRESS				CITY, STATE, ZIP CODE
	PHONE NUMBER	DATE OF EXAM		COMMENTS	

LENSES & FRAMES	DISPENSING PRACTICE NAME (IF DIFFERENT)						
	ADDRESS			CITY, STATE, ZIP CODE			
	PHONE NUMBER	DATE ORDERED		CHARGES			
	INSTRUCTIONS Attach your receipts to this form and mail to: VBA 400 Lydia Street, Suite 300 Carnegie, PA 15106 Or fax form and receipts to: 412-881-4898			Single vision	\$ _____	Bifocal	\$ _____
				Trifocal	\$ _____	Progressives	\$ _____
			Lenticular	\$ _____	Tint	\$ _____	
			Scratch coat	\$ _____	Anti reflective	\$ _____	
			Photochromic	\$ _____	Polycarbonate	\$ _____	
			UV coating	\$ _____	Low vision aids	\$ _____	
			Elective Contacts	\$ _____	Lasik (if covered by plan)	\$ _____	
			Contact Eval/fit	\$ _____			
			Medically required contacts (attach doctor's letter)			\$ _____	
			Charge for new frame (if any)			\$ _____	
			Total Charges			\$ _____	

*** THIS FORM IS FOR SERVICES THROUGH A NON-PARTICIPATING PROVIDER ONLY ***