



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

- Employee completes ALL parts of this form. Please complete PART 1 **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 employee's address on file.

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

EMPLOYEE'S FULL NAME		LAST 4 DIGITS OF SSN #	WORK PHONE #	HOME PHONE #
HOME ADDRESS		CITY, STATE, ZIP CODE		EMPLOYER NAME
PATIENT'S FULL NAME		RELATIONSHIP TO EMPLOYEE	EMPLOYEE DATE OF BIRTH	PATIENT 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.				
MEMBER/EMPLOYEE SIGNATURE				DATE

PART 2: USE A SEPARATE FORM FOR EACH FAMILY MEMBER

EXAM	PRACTICE NAME		<input type="checkbox"/> OD <input type="checkbox"/> 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 300 Weyman Road, Suite 400 Pittsburgh, PA 15236 Or fax form and receipts to: 412-881-4898		Single vision	\$ _____	Bifocal	\$ _____
			Trifocal	\$ _____	Progressives	\$ _____
		Lenticular	\$ _____	Tint	\$ _____	
		Scratch coat	\$ _____	Anti reflective	\$ _____	
		Photochromic	\$ _____	Polycarbonate	\$ _____	
		UV coating	\$ _____	Elective contacts	\$ _____	
		Low vision aids	\$ _____	Lasik (if covered by plan)	\$ _____	
		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 ***