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

1. Policyholder completes ALL parts of this form. Please complete all **before** printing this form.
2. A separate Reimbursement Form is required for each family member.
3. Please attach all itemized receipts to this form. Please be certain that your itemized receipts match the information entered below.
4. Mail or fax completed forms to VBA at the address listed below within 90 days of the Date of Service.
5. 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	

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

Note: Your itemized receipts must include the information indicated above. If your receipts do not reflect the information above, your claim cannot be processed.

CHARGES

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 ***