

# VSP<sup>®</sup> Vision Care Claim Form

To request reimbursement, complete the following form and submit a legible itemized receipt to VSP by mail, fax, or e-mail. Receipts must include: patient's name, provider's name, date of service, complete description of each service provided and amount paid for each service. Please retain a copy for your records.

**Mail** VSP Vision Care  
3007 Kingston Road, Suite 224  
Toronto, ON M1M 1P1  
Canada

**Fax** 877.463.3037

**Email** canadianclaims@vsp.com

## Member Information

Member's ID or SIN	Date of Birth MM/DD/YYYY
<input type="text"/>	<input type="text"/>

First Name	Last Name
<input type="text"/>	<input type="text"/>

Address
<input type="text"/>

City	Province	Postal code
<input type="text"/>	<input type="text"/>	<input type="text"/>

## Patient Information

First Name	Last Name
<input type="text"/>	<input type="text"/>

Member <input type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>	Domestic Partner <input type="checkbox"/>	Date of Birth MM/DD/YYYY
				<input type="text"/>

If the patient is a child over the age of 18:

Is the child a full-time student? Yes  No  Name of School \_\_\_\_\_

Is the child physically impaired? Yes  No

## Claim Information (Dollar amounts must match the attached receipts)

Exam <input type="checkbox"/>	\$ <input type="text"/>	Lens Type: (Choose one)	Date Services Were Received MM/DD/YYYY	
Frame <input type="checkbox"/>	\$ <input type="text"/>			Single <input type="checkbox"/> Progressive <input type="checkbox"/>
Lens <input type="checkbox"/>	\$ <input type="text"/>			Bi-Focal <input type="checkbox"/> Lenticular <input type="checkbox"/>
Total Paid	\$ <input type="text"/>			Tri-Focal <input type="checkbox"/> Contacts <input type="checkbox"/>

## Provider Information

Name
<input type="text"/>

Address
<input type="text"/>

City	Province	Postal code
<input type="text"/>	<input type="text"/>	<input type="text"/>

