ALLIED PILOTS ASSOCIATION
VISION CLAIM FORM
under the VOLUNTARY SUPPLEMENTAL MEDICAL AND CUSTODIAL CARE BENEFIT PLAN

Out-of-Network Claim Form

SECTION A **Complete this section for all claims.**	Member Name *(Last, First, Middle Initial)*	Member's ID or Social Security Number
	Mailing Address *(☐ Check if new address.)*	
	City State Zip Code	Date of Birth *(Month/Day/Year)*
SECTION B **Complete this section for Dependent claims only.**	Patient Name *(Last, First, Middle Initial)*	Patient Date of Birth *(Month/Day/Year)*
	Relationship to Member	
	If patient is a child (and over the age 26): Is the child physically impaired? ☐ Yes ☐ No	

SECTION C
Complete this section for all claims.

REIMBURSEMENT REQUEST INFORMATION

Date services were received ________________

Services received (please circle any that apply and provide the amount paid for each)

Exam	$ ____________________
Lenses: Single Vision	$ ____________________
Bifocal	$ ____________________
Trifocal	$ ____________________
Progressive	$ ____________________
Lenticular	$ ____________________
Lens Options:	
Tint	$ ____________________
Other*	$ ____________________
(Includes Scratch Coatings, Anti-Reflective Coatings, etc.)	
Frame	$ ____________________
Contact Lenses	$ ____________________
Contact Fitting and/or Evaluation	$ ____________________

SECTION D **Complete this section for all claims.**	Provider/Optical Shop Name	
	Address	
	City State Zip Code	Phone Number

Mail this form along with related receipts to:

VSP
Attn: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

*For more information please visit the Vision Service Plan Web site at **www.vsp.com***