# 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 |
|---|---|
| Modern Eyes Optical Dr. Hayley Woodall | |

| ADDRESS | CITY, STATE, ZIP CODE |
|---|---|
| 1635 Manheim Pike | Lancaster, PA 17601 |

| PHONE NUMBER | DATE OF EXAM | COMMENTS |
|---|---|---|
| 717-299-0925 | | |

**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 ***