

**VSP Vision Care Plan
Out-of-Network Claim Form**

Employer: Wright State University

Employee's name _____ SSN _____

Address _____

Patient's name _____ Self Spouse Dependent

Attach an itemized bill with includes date of service and complete information regarding services received.

Mail the bill and this form to:

Out-of-Network Claims Department
Vision Service Plan
PO Box 997105
Sacramento, CA 95899-7105