VISION INSURANCE PLAN OF AMERICA, INC.

NON-PARTICIPATING PROVIDER
REIMBURSEMENT PROCEDURE

IF YOU ARE IN AN AREA THAT DOES NOT HAVE A PARTICIPATING PROVIDER OR YOU CHOOSE NOT TO USE A PREFERRED PROVIDER, PLEASE FOLLOW THE PROCEDURE OUTLINED BELOW:

1. **Select a provider.**
2. **Attach an itemized statement or receipt to this form.**
3. **Complete the following information:**

Employee Name ______________________________

Employee ID ______________________________
(on ID card)

Home Address ______________________________

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Patient Name ______________________________

Patient ID ______________________________
(on ID card)

Plan Number ______________________________

Employer ______________________________

4. **Mail this form and your statement/receipt to VIPA at:**

Vision Insurance Plan of America
PO Box 44077
West Allis, WI 53214-7077

414-475-1875 1-800-883-5747