Vision Benefit Statement

THIS IS NOT A BILL

VSP Vision Care

<Recipient Name>
(1) <Street Address>
<Address Line 2
<City, State & ZIP code>

(2) **Date of Notice:** MM/DD/YYYY
(3) **Name of Plan:** VSP
For Inquiries: VSP
(4) P.O. Box 9971000
Sacramento, CA 95899-7100

(5) **Telephone:** <1-###-###-####>
(6) **TDD/TTY:** 1-800-428-4833
(7) **Website:** vsp.com

Case Details

This document contains important information that you should retain for your records.

This is not a bill.

This document serves as notice of a potential adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see the following pages for information about your appeal rights).

Name: (8)		**Case Number:** (9)
Claim #: (10)		**Date of Service: MM/DD/YYYY** (11)
Provider: (12)		
TOTAL AMOUNT CHARGED: (13) $	**YOUR COSTS:** (14) $ The provider may bill you for this amount if you have not yet paid.	**TOTAL SAVINGS:** (15) $

Diagnosis Code	Diagnosis Description
	(16)

Date Services Received	Service Code	Service Description	Amount Billed	Copay	Other Amounts Not Covered	Claim Status PD=paid DN=denied	Remark Code**
(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)

Claim Status Summary: (25)

**Explanation of Basis for Determination:

Remark Code **Remark Description**

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Practice Name: 27
Practice Address: 28

Vision Benefit Statement Legend

Number	Description
1	Member or dependent 18 years or older name and address.
2	Date Vision Benefit Statement is issued.
3	Name of vendor supplying the Vision Benefit Statement
4	Vendor's address for Vision Benefit Statement inquiries
5	Vendor's custom toll free phone number. (For Medicare BCNA or MA Plus Blue PPO's VSP toll free number will display.)
6	Vendor's TDD/TTY number for hearing impaired.
7	Vendor's web address.
8	Patient's name.
9	Unique VSP ID number associated with patient's paid claim.
10	VSP number assigned to patient's paid claim.
11	Date services were received.
12	Provider name.
13	Total amount provider charged for the services.
14	Patient's out of pocket cost, if available.
15	Amount patient saved with VSP coverage, if available.
16	Patient's diagnosis code and description.
17	Date services were received.
18	Service/Treatment code.
19	Service/Treatment description.
20	Amount billed per service.
21	Patient's copayment.
22	Amounts over plan allowance or non-covered options. For example: Frame overage.
23	Claim Status – PD=Paid and DN=Denied
24	Claim line level remark codes (explanations on the back of the Vision Benefit Statement)
25	Claim header level remark codes (explanations on the back of the Vision Benefit Statement)
26	Explanation of remark codes
27	Practice Name (could be different than the provider name)
28	Practice Address