



VSP Savings Statement

Patient's Name: _____ Date of Service: _____ Doctor: _____


	Cost Without VSP	VSP Member
Copay(s):		
• Exam	_____	_____
• Eyewear	_____	_____
Eye Exam:	_____	_____
Eyeglasses:		
• Lenses	_____	_____
• Frame	_____	_____
• Lens Enhancements	_____	_____
	_____	_____
	_____	_____
	_____	_____
Contact Lenses:		
• Fitting/Evaluation	_____	_____
• Lenses	_____	_____
Total Cost for Services	_____	_____
	(Without coverage)	(With coverage)

Your Savings with VSP: \$ _____

Ask your doctor about extra savings VSP Members receive on additional pairs on prescription glasses and sunglasses.

Attached is a wallet-sized reference card that you may want to use as a reminder for your next exam. Visit vsp.com to review your plan coverage before your appointment.

VSP puts you first and guarantees your satisfaction. If you're not 100% happy, we'll make it right.



Reference Card

My Doctor: _____

Phone: _____

Next Exam: _____

Ask your doctor about extra savings VSP Members receive on additional pairs of prescription glasses and sunglasses. This card does not guarantee eligibility. Your VSP doctor will verify eligibility.