Coordination of Benefits Acknowledgement

Doctor Name:

_____

Patient Name:

_____

Date of Service: _____

Coordinating benefits can help you maximize your coverage and lower your out-of-pocket costs.

I, _____ (patient name) acknowledge that

- The doctor will submit a claim to VSP® for all covered vision services that have been provided.
- The doctor will coordinate coverage with my VSP benefit and other VSP benefits or other insurance plan(s) that I have coverage with.
- This will use my VSP vision benefit for the current eligibility period.

Patient signature: _____ Date: _____

If you have questions about your VSP benefit, please call VSP Member Services at **800.877.7195**.