VSP Vision care for life

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: $

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.

VSP **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.

Thank you for choosing VSP as your trusted eyecare advisor.

JOB#15371DR 12/13