VALENCIA OPTOMETRY

VSP Insurance Form

1. Primary Insurance Member

Name: _____

Date of Birth: _____

Employer: _____

Social Security Number (last 4 digits only):_____

2. Patient *(if different from Primary Insurance Member)*

Name:_____

Date of Birth: _____ Relationship to Insured: _____

Full Time Student? ☐ No ☐ Yes

Lifetime Signature on File: I authorize the release of any medical or other information necessary to determine my benefits and process my insurance claims. I request that payments of authorized medical benefits be made on my behalf to the physician for any services and/or materials provided to me. I authorize the use of this signature on all my insurance submissions. I understand that I am financially responsible for all charges not covered by my insurance.

Lifetime Patient Signature X_____