Focus® benefit guide

plan overview

FOCUS is an eye care product offered by Ameritas through VSP (Vision Service Plan).

how to find a VSP provider

1. Call the VSP customer service department at 800-877-7195.2. Log-on to our website, ameritasgroup.com, select the eye care link and "Find a Provider Directory."

how to use the benefits

1. Contact a VSP participating provider to make an appointment.

2. Tell the VSP participating provider you are a VSP member and give them the following information:
A. Your name
B. Date of birth
C. The name of the group that provides your VSP coverage (Ameritas)
D. The covered member's VSP identification number

If a VSP provider is unable to locate your information or if there is a problem with your eligibility, you can call Ameritas at 800-659-2223.

3. After you make an appointment, your provider and VSP will handle the rest. The provider will check your eligibility for services and plan coverage.

if you see a non-participating provider

1. Pay the provider the amount in full and request a copy of the bill that shows the amount charged for the eye examination, lens type and frame.

2. Send a copy of the itemized bill to VSP.

The following information is needed:
A. Member's name and mailing address
B. Member's identification number
C. Member's employer or group name
D. Patient's name, relationship to the member and date of birth

You may submit the information on a HCFA-1500 form or any generic insurance claim form that may be available from your non-participating provider upon request.

Please mail the itemized bill and form to the following address:

VSP (Vision Service Plan)
P.O. Box 997100
Sacramento, CA 95899-7100

*NOTE: Claims for reimbursement must be filed within six months of the date of the service.

Out-Of-Network Reimbursement Form

Member Information:

Member's Name:_____ **Date of Birth:**_____

Address:_____

City:_____ **State:**_____ **ZIP Code:**_____

Member's ID or Social Security Number:_____

Name of Group/Employer:_____

Patient Information:

Patient's Name:_____ **Date of Birth:**_____

Relationship to Member:_____

If the patient is a child (and over the age of 18):

Is the child a full time student? Y/N **Name of School:**_____

Is the child physically impaired? Y/N

Reimbursement Request Information:

Date Services were received:_____

Services received (please circle any that apply and provide the amount paid for each)

Exam $_____

Lenses: Single Vision
Bifocal
Trifocal $_____
Progressive
Lenticular

Lens Options:

Tint $_____

Other* $_____
*(Includes Scratch Coatings, Anti-Reflective coatings, etc.)

Frame $_____

Contact Lenses $_____

Contact fitting &/or Evaluation $_____

Provider/Optical Shop Name:_____ **Phone Number:**_____

Address:_____

City:_____ **State:**_____ **ZIP Code:**_____

Coordination of Benefits Information:

If you are coordinating benefits with another insurance carrier, we need a complete copy of the Explanation of Benefits from your primary insurance carrier. The Explanation of Benefits must indicate the service(s) which were received, as well as the amount paid, denied, or applied to your deductible. This information can be obtained from the provider who performed your recent services.

Submit this form along with related receipts to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

For additional information on your eyecare benefits, please visit our website at: VSP.com