Vision Benefits – Claim Instructions

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

TO THE EMPLOYEE

1. Complete items one (1) through twenty-two (22) in full.
2. Complete items 23-27 only if other medical coverage exists.
3. Be certain to sign the authorization to release information block (28).
4. If you wish to have your benefits for this claim paid directly to your physician or supplier, sign the block (29).
5. If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.
6. Incomplete forms will delay payment.
7. Send the completed benefits request and the bills to the Aetna office address listed on the back of your medical ID card.

TO THE DOCTOR

1. Complete items thirty (30) through forty-four (44) in full.
2. If the employee indicates that benefits should be paid directly to the doctor, then these benefits will be sent directly to you with an information copy of the transactions to the employee.

TO THE DISPENSER

1. Complete items forty-five (45) through fifty-five (55) in full.
2. If the employee indicates that benefits should be paid directly to the dispenser, then these benefits will be sent directly to you with an information copy of the transactions to the employee.

Aetna® Vision Benefits Request

Refer to the back of your ID card for claim mailing address.

TO BE COMPLETED BY EMPLOYEE

1. Employer's Name
2. Policy/Group Number
3. Employee's Aetna ID Number
4. Employee's Name
5. Employee's Birthdate *(MM/DD/YYYY)*
6. ☐ Active ☐ Retired Date of Retirement
7. Employee's Address (include zip code) ☐ Address is new
8. Employee's Daytime Telephone Number ( )
9. Patient's Name
10. Patient's Aetna ID Number
11. Patient's Birthdate *(MM/DD/YYYY)*
12. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from employee)
14. Patient's Sex ☐ Male ☐ Female
15. Full Time Student ☐ No ☐ Yes
16. Patient's Expected Graduation Date
17. Name of School City
18. Patient's Marital Status ☐ Married ☐ Single
19. Is patient employed? ☐ No ☐ Yes
20. Name & Address of Employer
21. Is claim related to an accident? ☐ No ☐ Yes If yes, date _____ time _____ ☐ am ☐ pm
22. Is claim related to employment? ☐ No ☐ Yes
23. Are any family members expenses covered by another group health plan, group pre-payment plan (Blue Cross-Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? ☐ No ☐ Yes
24. If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:
25. Member's ID Number
26. Member's Name
27. Member's Birthdate *(MM/DD/YYYY)*

28. To all providers of health care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.
Patient's or Authorized Person's Signature _____ Date _____

29. I authorize payment of vision care benefits to the doctor and/or dispenser.
Patient's or Authorized Person's Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

30. Doctor's Name & Address (include zip code)
31. Telephone Number ( )
32. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.
33. National Provider Identifier
34. Title ☐ M.D. ☐ D.O. ☐ O.D.
35. Examination Date(s)
36. Has Cataract surgery been performed? ☐ No ☐ Yes
37. Can visual acuity be restored to 20/70 in better eye with conventional eyeglasses? ☐ No ☐ Yes
38. Does patient require a prescription change at this time? ☐ No ☐ Yes
39. Diagnostic Code(s) _____ ; _____ ; _____ ; _____ ; _____
40. Indicate diagnosis or nature of disease or injury or vision disorder, indicate procedure code numbers
41. Visual acuity corrected to

42. Doctor's Prescription

	Sphere	Cylinder	Axis	Prism	Base
R.E.	•	•			
L.E.	•	•			
Reading Add		R.E.	+ •	L.E.	+ •

43. Professional Service — Amount

Exam (HCPC/CPT) _____	$
Sales Tax (if any)	$
Total	$
Amount Paid by Patient	$

44. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures.
Doctor's Signature _____ Date _____

Note: In lieu of dispenser completing this section a laboratory bill can be attached. Dispenser must sign this form, enter amount paid by patient.

45. Dispenser's Name & Address (include zip code)
46. Telephone Number ( )
47. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.
48. National Provider Identifier
49. Title ☐ Optician ☐ Optometrist ☐ Ophthalmologist
50. Date ☐ Order _____ ☐ Delivery _____
51. Material Supplied ☐ Glass ☐ Plastic ☐ Oversized ☐ Tint # _____ ☐ Pair ☐ 1/2 Pair ☐ Other _____

52. Type of lenses dispensed:
☐ None
☐ Single (HCPC/CPT) _____
☐ Bifocal (HCPC/CPT) _____
☐ Trifocal (HCPC/CPT) _____
☐ Lenticular (HCPC/CPT) _____
☐ Contacts (HCPC/CPT) _____
☐ Sunglasses (HCPC/CPT) _____
☐ Other (specify below) (HCPC/CPT)
_____

53. If contact lenses, please complete
☐ Therapeutic (HCPC/CPT) _____
☐ Non-Therapeutic (HCPC/CPT) _____
☐ Hard Lenses (HCPC/CPT) _____
☐ Soft Lenses (HCPC/CPT) _____

53a. If frames, please complete
☐ Frames (HCPC/CPT) _____

54. Professional Service — Amount

	Lens Charge	$
	Frame Charge	$
Optional	Lens	$
	Frame	$
Disp. Fee	Lens	$
	Frame	$
	Sales Tax (if any)	$
	Total	$
	Amount Paid By Patient	$

55. I hereby certify that I have performed the services as indicated hereon and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures.
Dispenser's Signature _____ Date _____