Vision Benefits – Claim Instructions

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

Attention California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Attention New York 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention 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.

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

TO THE DOCTOR

1. Complete items thirty (30) through forty-three (43) 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-four (44) through fifty-three (53) 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 Medical ID card for claim mailing address.

TO BE COMPLETED BY EMPLOYEE

1. Employer's Name
2. Policy/Group Number
3. Employee's 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 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. Title ☐ M.D. ☐ D.O. ☐ O.D.
34. Examination Date(s)
35. Has Cataract surgery been performed? ☐ No ☐ Yes
36. Can visual acuity be restored to 20/70 in better eye with conventional eyeglasses? ☐ No ☐ Yes
37. Does patient require a prescription change at this time? ☐ No ☐ Yes
38. Diagnostic Code(s) _____ ; _____ ; _____ ; _____ ; _____
39. Indicate diagnosis or nature of disease or injury or vision disorder, indicate procedure code numbers
40. Visual acuity corrected to
41. Doctor's Prescription

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

42. Professional Service — Amount

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

43. 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.

44. Dispenser's Name & Address (include zip code)
45. Telephone Number ( )
46. 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.
47. Title ☐ Optician ☐ Optometrist ☐ Ophthalmologist
48. Date ☐ Order _____ ☐ Delivery _____
49. Material Supplied ☐ Glass ☐ Plastic ☐ Oversized ☐ Tint # _____ ☐ Pair ☐ 1/2 Pair ☐ Other _____
50. 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)
51. If contact lenses, please complete
☐ Therapeutic (HCPC/CPT) _____
☐ Non-Therapeutic (HCPC/CPT) _____
☐ Hard Lenses (HCPC/CPT) _____
☐ Soft Lenses (HCPC/CPT) _____
51a. If frames, please complete
☐ Frames (HCPC/CPT) _____
52. Professional Service — Amount

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

53. 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 _____