



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 Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island 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 Residents:** *For your protection California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.* **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 a 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. **Attention Louisiana 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 is guilty of a crime and may be subject to fines and confinement in prison. **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 Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri 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, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **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 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 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 Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **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 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 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 Texas 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 intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **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 nineteen (19) in full.
2. Complete items twenty (20) through twenty-four (24) only if other medical coverage exists.
3. Be certain to sign the authorization to release information in block twenty-five (25).
4. If you wish to have your benefits for this claim paid directly to your physician or supplier, sign block twenty-six (26).
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 twenty-seven (27) through forty-one (41) 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-two (42) through fifty-two (52) 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.



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. <input type="checkbox"/> Active <input type="checkbox"/> Retired Date of Retirement	7. Employee's Address (include ZIP Code) <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
13. Patient's Address (if different from employee)			14. Patient's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
15. Patient's Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	16. Is patient employed? <input type="checkbox"/> No <input type="checkbox"/> Yes		17. Name and Address of Employer
18. Is claim related to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, date _____ time _____ <input type="checkbox"/> am <input type="checkbox"/> pm			19. Is claim related to employment? <input type="checkbox"/> No <input type="checkbox"/> Yes
20. 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? <input type="checkbox"/> No <input type="checkbox"/> Yes		21. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:	
22. Member's ID Number	23. Member's Name		24. Member's Birthdate (MM/DD/YYYY)
25. 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 _____			
26. 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 DOCTOR OR SUPPLIER

27. Doctor's Name & Address (include ZIP Code)		28. Telephone Number ()	29. 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.			
30. National Provider Identifier		31. Title <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> O.D.	32. Examination Date(s)			
33. Has Cataract surgery been performed? <input type="checkbox"/> No <input type="checkbox"/> Yes		34. Can visual acuity be restored to 20/70 in better eye with conventional eyeglasses? <input type="checkbox"/> No <input type="checkbox"/> Yes	35. Does patient require a prescription change at this time? <input type="checkbox"/> No <input type="checkbox"/> Yes			
36. Diagnostic Code(s) _____ ; _____ ; _____						
37. Indicate diagnosis or nature of disease or injury or vision disorder, indicate procedure code numbers				38. Visual acuity corrected to		
39. Doctor's Prescription			40. Professional Service	Amount		
Sphere	Cylinder	Axis	Prism	Base	Exam (HCPC/CPT) _____	\$ _____
R.E.	•	•			Sales Tax (if any)	\$ _____
L.E.	•	•			Total	\$ _____
Reading Add	R.E.	+ •	L.E.	+ •	Amount Paid by Patient	\$ _____
41. 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.

42. Dispenser's Name & Address (include ZIP Code)		43. Telephone Number ()	44. 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.	
45. National Provider Identifier		46. Title <input type="checkbox"/> Optician <input type="checkbox"/> Optometrist <input type="checkbox"/> Ophthalmologist		
47. Date <input type="checkbox"/> Order _____ <input type="checkbox"/> Delivery _____		48. Material Supplied <input type="checkbox"/> Glass <input type="checkbox"/> Plastic <input type="checkbox"/> Oversized <input type="checkbox"/> Tint # _____ <input type="checkbox"/> Pair <input type="checkbox"/> 1/2 Pair <input type="checkbox"/> Other _____		
49. Type of lenses dispensed: <input type="checkbox"/> None <input type="checkbox"/> Single (HCPC/CPT) _____ <input type="checkbox"/> Bifocal (HCPC/CPT) _____ <input type="checkbox"/> Trifocal (HCPC/CPT) _____ <input type="checkbox"/> Lenticular (HCPC/CPT) _____ <input type="checkbox"/> Contacts (HCPC/CPT) _____ <input type="checkbox"/> Sunglasses (HCPC/CPT) _____ <input type="checkbox"/> Other (specify below) (HCPC/CPT) _____	50. If contact lenses, please complete: <input type="checkbox"/> Therapeutic (HCPC/CPT) _____ <input type="checkbox"/> Non-Therapeutic (HCPC/CPT) _____ <input type="checkbox"/> Hard Lenses (HCPC/CPT) _____ <input type="checkbox"/> Soft Lenses (HCPC/CPT) _____		51. Professional Service	
50a. If frames, please complete <input type="checkbox"/> Frames (HCPC/CPT) _____		Lens Charge	\$ _____	
		Frame Charge	\$ _____	
		Optional Lens	\$ _____	
		Frame	\$ _____	
		Disp. Fee Lens	\$ _____	
		Frame	\$ _____	
		Sales Tax (if any)	\$ _____	
		Total	\$ _____	
		Amount Paid By Patient	\$ _____	
52. 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 _____				

1-00-4-1, 11, 40512 (H 1-00-3-101, 00-53- ()), 2001Y-1Y1 1 R, 50, 20201h1 1-00-3-101, 00-53- ()

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TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

walang Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang bayad. (Tagalog)

inígíí T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo Diné k'ehjí naaltsos bee atah nílįigo nani béésh bee hane'é bikáá' áajį' t'áá jíík'e hólne'. (Navajo)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

teitit (ID) Për asistencë në gjuhën shqipe telefononi falas në numrin e regjistruar në kartën tuaj të identifikimit. (Albanian)

Niba urondera uwugufasha mu Kirundi, twakure ku busa ku inomero iri ku ikarata karangamuntu yawe. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawga ang numero nga gilista sa imong kard sa kailhanan nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহায়তার জন্য আপনার আইডি কার্ডে যে নম্বরটি তালিকাভুক্ত রয়েছে বিনামূল্যে তাতে কল করুন। (Bengali-Bangala)

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား) ဖြင့် ဘာသာစကားအကူအညီရယူရန် သင့်အိုင်ဒီကတ် ပေါ်တွင် ပေးထားသည့်ဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။ (Burmese)

Per rebre assistència en (català), truqui al número de telèfon gratuït que apareix a la seva targeta d'identificació. (Catalan)

Para ayuda gi fino' (Chamoru), ágang l numiru ni mangaige gi iyo-mu 'ID card', sin gãstu.. (Chamorro)

Bé m̀ ké gbo-kpá-kpá dyé dé Bàsóò wùdùùn wěé, d́á nòbà b́é ɔ cééà b́ó nì dyí-dyoìn-bě̀ò k̄ɛ́ b́ó pídyi.
(Kru-Bassa)

بو وەرگرتنی رینوینی یتوهندیدار به زمان به زمان به ژماره ی خۆرای ی نووسراو له کارت ی بیناسی خۆتادا په یوهندی بکهن.
(Kurdish)

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ,
ກະລຸນາໂທຫາໝາຍເລກທີລະບຸໃນບັດປະຈຳຕົວຂອງທ່ານໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

तील भाषा (मराठी) सहाय्यासाठी तुमच्या आयडी कार्डवर सूचिबद्ध करण्यात आलेल्या क्रमांकावर
कोणत्याही खर्चाशिवाय कॉल करा. (Marathi)

Ñan bök jipañ ilo Kajin Majol kwon kallok nōmba eo ej walok ilo kaat in ID eo am ejjelok wōnān.
(Marshallese)

Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl nempe me sansal pohn noumw ID
koard ni sohte isais. (Micronesian-Pohnpeian)

សម្រាប់ជន្មួយភាសាជា ភាសាខ្មែរ
សូមទូរស័ព្ទតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នកដោយឥតគិតថ្លៃ។ (Mon-Khmer,
Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि तपाईंको परिचय-पत्रमा उल्लेख गरिएको नम्बरमा फोन
गर्नुहोस् । (Nepali)

Tën kuɔny ɛ thok ɛ Thuɔŋjäŋ ɔl akuɛn cī reec ɛ kaaddu kōu kecīn ayōc.(Nilotic-Dinka)

For språkassistanse på norsk, ring nummeret på ID-kortet ditt kostnadsfritt. (Norwegian)

Fer Hefle in Deitsch, ruf die Fonnummer aa die uff dei ID Kaarde iss. Es Aaruf koschtet nix.
(Pennsylvania Dutch)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی
(Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de
identificação. (Portuguese)

(Punjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Pentru asistență lingvistică în românește telefonați la numărul gratuit indicat pe cardul dvs. de membru de
la Aetna. (Romanian)

