



# 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 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. **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.

Patient/Member Signature:	Date:
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**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 MEMBER

1. Complete items one (1) through twenty-one (21) in full.
2. Complete items twenty-two (22) through twenty-six (26) only if other medical coverage exists.
3. Be certain to sign the authorization to release information in block twenty-seven (27).
4. If you wish to have your benefits for this claim paid directly to your physician or supplier, sign block twenty-eight (28).
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. Attach itemized bills or ask your health care provider to complete the applicable section on the reverse side. The bills must include:
 

- patient's name	- condition being treated	- type of service(s) rendered	- date(s) of service(s)	- relationship to member
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 If this information is missing, write it on the bill and sign your name.
7. If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. This information can be copied from the prescription bottle or box. Receipt must contain:
 

- drug name	- purchase date	- prescription number	- pharmacy name/address	- dose per/day
- nature of illness or injury	- quantity	- charge	- strength	- physician's name
8. Retain copies of your bills for your record.
9. Send the completed benefits request and the bills to:

**Aetna Life Insurance Company**  
**PO Box 981106**  
**El Paso, TX 79998**

### TO THE PHYSICIAN OR SUPPLIER

1. Complete items twenty-nine (29) through forty-five (45) in full.
2. If the member indicates that benefits should be paid directly to the physician or supplier, then these benefits will be sent directly to you with an information copy of the transactions to the member.
3. 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			
Sphere	Cylinder	Axis	Prism	Base	Exam (HCPC/CPT) _____	Amount
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) _____  50a. If frames, please complete <input type="checkbox"/> Frames (HCPC/CPT) _____		51. Professional Service	
		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 \_\_\_\_\_

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.





Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Tongan	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he fika 'oku hā atu 'i ho'o ID kaati.
Turkish	Dil hizmetlerine ücretsiz olarak erişmek için kimlik kartınızdaki numarayı arayın.
Ukrainian	Щоб безкоштовні отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікаційній картці.
Urdu	لسانی خدمات تک مُفت رسائی کے لیے، اپنے بیمہ کے ID کارڈ پر درج نمبر پر کال کریں۔
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Yiddish	צו באקומען שפראך סערוויסעס פון אפצאל, רופט דעם נומער אויף אייער ID קארטל.
Yoruba	Láti ráyèsí àwọn iṣẹ̀ èdè fún ọ̀ lófẹ́ẹ̀, pe nọmbà tó wà lórí káàdì ìdánimọ̀ rẹ̀.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Mo fesoasoani tau gagana I le Gagana Samoa vala’au le numera o lo’o lisiina I luga o lau pepa ID e aunoa ma se totogi. (Samoan)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj naveden na poledini Vaše identifikacijske kartice. (Serbo-Croatian)

Fii yo on hebu balal e ko yowitii e haala Pular noddee e dii numero ji lintaa di ka kaydi dantite mon. Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukhitaji usaidizi katika lugha ya Kiswahili piga simu kwa nambari iliyoorodheshwa kwenye Kitambulisho chako bila malipo. (Swahili)

ܩܘܼܠܽܘܼܢ ܥܰܘܼܕܽܘܼܢ ܕܰܗܰܘܰܢܰܘܼܢ ܕܰܠܰܘܰܢܰܘܼܢ ܕܰܠܰܘܰܢܰܘܼܢ ܕܰܠܰܘܰܢܰܘܼܢ ܕܰܠܰܘܰܢܰܘܼܢ

(Syriac-Assyrian) ܩܘܼܠܽܘܼܢ ܥܰܘܼܕܽܘܼܢ ܕܰܗܰܘܰܢܰܘܼܢ ܕܰܠܰܘܰܢܰܘܼܢ ܕܰܠܰܘܰܢܰܘܼܢ ܕܰܠܰܘܰܢܰܘܼܢ ܕܰܠܰܘܰܢܰܘܼܢ

భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా మీ ఐడి కార్డు మీద ఉన్న నెంబరుకు కాల్ చేయండి (తెలుగు) (Telugu)

สำหรับความช่วยเหลือเรื่องทางด้านการภาษาเป็น (ภาษาไทย) โทรหมายเลขที่แสดงไว้บนบัตรประจำตัวของท่าน ฟรีไม่มีค่าใช้จ่าย (Thai)

Kapau ‘oku fiema’u hā tōkoni ‘i he lea faka-Tonga telefoni ki he fika ‘oku lisi ‘i ho’o kaati ID ‘o ‘ikai hā tōtōngi (Tongan)

Ren ánnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri ena nampaan tengewa aa makketiw wóon noumw ena chéen taropween ID nge esapw kamé ngonuk. (Trukese)

(Dilde) dil yardım için sayı hiçbir ücret ödemedi kimlik kartı listelenen diyoruz. (Turkish)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером, наданим у вашій ID-картці посвідчення особи. (Ukrainian)

اُردو ميں لساني معاونت کے لیے اپنے ID کارڈ پر درج نمبر پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)

פאר שפראך הילף אין אידיש רופט דעם נומער וואס שטייט אויף אייער אידענטײטעט קארטל פריי פון אפצאל.  
(Yiddish)

Fún àrànṣọwọ nípa èdè (Yorùbá) pe nọmbà tí a kọ sórí káàdi idánimọ ọ rẹ láì san owó kankan rárá. (Yoruba)