



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:
----------------------------------	--------------

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
------------------	---------------------------	-------------------------------	-------------------------	--------------------------

 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 (If you prefer not to disclose, leave blank) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary/Other	
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																					
<table border="1"> <thead> <tr> <th>Sphere</th> <th>Cylinder</th> <th>Axis</th> <th>Prism</th> <th>Base</th> </tr> </thead> <tbody> <tr> <td>R.E. _____</td> <td>• _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>L.E. _____</td> <td>• _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Reading Add _____</td> <td>R.E. _____</td> <td>+ • _____</td> <td>L.E. _____</td> <td>+ • _____</td> </tr> </tbody> </table>			Sphere	Cylinder	Axis	Prism	Base	R.E. _____	• _____				L.E. _____	• _____				Reading Add _____	R.E. _____	+ • _____	L.E. _____	+ • _____	Exam (HCPC/CPT) _____ \$ _____ Sales Tax (if any) \$ _____ Total \$ _____ Amount Paid by Patient \$ _____	
Sphere	Cylinder	Axis	Prism	Base																				
R.E. _____	• _____																							
L.E. _____	• _____																							
Reading Add _____	R.E. _____	+ • _____	L.E. _____	+ • _____																				
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
				Amount
		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.

Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obula, kpọọ nọmba nọ na kaadi njirimara gi
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကမၤကျိၣ်တၢ်မၤလၢအတၢ်ဖံးတၢ်မၤတဖၣ် လၢတၢ်အိၣ်ဒီးအပူၤလၢနကဘၣ်ဟ့ၣ်အိၣ်အိၣ်ကိးဘၣ်လိတံဖိနီၣ်လၢအိၣ်လၢနနိၣ်ဂီၤ ၁ (၅၅) အလံၤတက့ၤၼ်
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەستگیر ئەگەشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی (ID) کارتێ خۆت.
Lao	ເພື່ອຂ້າງປະຕິບັດບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໃບຫາເປີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डवरील क्रमांकावर फोन करा.
Marshallese	Ñan bōk jipañ kōn kajin ilo an ejjelōk wōñean ñan kwe, kwōn kallok nōmba eo ilo kaat in ID eo aṃ.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo búááh ílínígóó naaltsoos bee atah nílíigo nanitinígíí bee néého'dólzínígíí béésh bee hane'í biká'ígíí áají'í hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të kwoɾ yin ran de wëër de thokic ke cïn wëu kɔr keek tənɔŋ yin. Ke yin cɔl ran ye kɔc kuɔny në namba de abac tö në ID kard duön de tiit de nyin de panakim köu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian	Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.

