



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 Residents: For your protection California law requires 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 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 Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 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 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 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 1-22 in full.
2. Complete items 23-27 only if other medical coverage exists.
3. Be certain to sign the authorization to release information in block 28.
4. If you wish to have your benefits for this claim paid directly to your physician or supplier, sign 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:

SRC, an Aetna Company
Attn: Claim Department
PO Box 14079
Lexington, KY 40512-4079
Fax to: 1-859-455-8650
Phone: 1-888-772-9682

TO THE DOCTOR

1. Complete items 30-44 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 45-55 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.



Vision Benefits Request

Mail to: SRC, an Aetna Company
 Attn: Claim Department
 PO Box 14079
 Lexington, KY 40512-4079
 Telephone: 1-888-772-9682

Fax to: 1-859-455-8650

TO BE COMPLETED BY EMPLOYEE																									
1. Employer's Name			2. Policy/Group Number																						
3. Employee's Aetna ID Number or SSN		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 or SSN	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. Full Time Student <input type="checkbox"/> No <input type="checkbox"/> Yes	16. Patient's Expected Graduation Date	17. Name of School and City																				
18. Patient's Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single		19. Is patient employed? <input type="checkbox"/> No <input type="checkbox"/> Yes	20. Name and Address of Employer																						
21. 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				22. Is claim related to employment? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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 Aetna ID Number or SSN		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 <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> O.D.		35. Examination Date(s)																					
36. Has Cataract surgery been performed? <input type="checkbox"/> No <input type="checkbox"/> Yes		37. Can visual acuity be restored to 20/70 in better eye with conventional eyeglasses? <input type="checkbox"/> No <input type="checkbox"/> Yes		38. Does patient require a prescription change at this time? <input type="checkbox"/> No <input type="checkbox"/> 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					43. Professional Service Amount																				
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Sphere</th> <th style="width: 10%;">Cylinder</th> <th style="width: 10%;">Axis</th> <th style="width: 10%;">Prism</th> <th style="width: 10%;">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) _____ \$ _____
Sphere	Cylinder	Axis	Prism	Base																					
R.E. •	•																								
L.E. •	•																								
Reading Add	R.E. + •		L.E. + •																						
					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 <input type="checkbox"/> Optician <input type="checkbox"/> Optometrist <input type="checkbox"/> Ophthalmologist		51. 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 _____																					
50. Date <input type="checkbox"/> Order _____ <input type="checkbox"/> Delivery _____		52. 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) _____		53. 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) _____																					
53a. If frames, please complete <input type="checkbox"/> 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 _____																									