Vision Provider's Statement

Aetna Global Benefits®

Coverage underwritten by Aetna Life Insurance Company and Aetna Life & Casualty (Bermuda) Ltd.

- ***This form should be completed and submitted if an itemized bill is not provided by the vision supply dispenser to accompany the Claim Form (GR-68069) or if the vision claims being submitted for consideration are charges incurred from a physician. The Summary of Reimbursement section of the Vision Benefit Request form will identify the party to whom benefit payments should be made payable/sent.***
- Fully itemized lab bills and receipts from a vision supply dispenser should include: Patient's name and relationship to employee, Provider/Dispenser Name/address/telephone number, type of lense dispensed (i.e. contacts, single vision, bifocal, etc), type of frame (wire, plastic, etc), date the appliance (i.e. glasses) was delivered to the patient, amount charged for each service/supply.
- ***Dispenser NOTE:*** If you have not provided fully itemized bills to the patient, ***you*** should complete items 19-28 of this form, attach it to all bills and a completed Claim Form **(GR-68069)**, and mail them to the address on the back of the member's insurance Identification Card or **Aetna Global Benefits,**
  P.O. Box 30258, Tampa, FL, 33630-3258, U.S.A.
- Employee completes Sections 1-2.
- Doctor completes Sections 3 - 18.
- Dispenser completes Sections 19 - 28.

1. Employee's Name				2. Employee's Social Security/I.D. Number
3. Patient's Name				4. Patient's Birthdate (mm/dd/yyyy)
5. Doctor's Name & Address (include zip code)	6. Telephone Number ( )		7. If applicable, enter the taxpayer identifying number to be used for U.S. 1099 reporting purposes. You are required under authority of U.S. law to furnish your taxpayer identifying number.	
	8. Title ☐ M.D. ☐ D.O. ☐ O.D.		9. Examination Date(s) (mm/dd/yyyy)	
	10. Has Cataract surgery been performed? ☐ No ☐ Yes	11. Can visual acuity be restored to 20/70 in better eye with conventional eyeglasses? ☐ No ☐ Yes	12. Does patient require a prescription change at this time? ☐ No ☐ Yes	
13. Diagnostic Code(s) _____ ; _____ ; _____ ; _____ ; _____				
14. Indicate diagnosis or nature of disease or injury or vision disorder, indicate procedure code numbers				15. Visual acuity corrected to

16. Doctor's Prescription						17. Professional Service	Amount
Sphere		Cylinder	Axis	Prism	Base	Examination Charge	$
R.E.	•	•				Sales Tax (if any)	$
L.E.	•	•				Total	$
Reading Add		R.E.	+ •	L.E.	+ •	Amount Paid by Patient	$

18. 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.

19. Dispenser's Name & Address (include zip code)	20. Telephone Number ( )	21. If applicable, enter the taxpayer identifying number to be used for U.S. 1099 reporting purposes. You are required under authority of U.S. law to furnish your taxpayer identifying number.	
	22. Title ☐ Optician ☐ Optometrist ☐ Ophthalmologist		
	23. Date (mm/dd/yyyy) ☐ Order_____ ☐ Delivery _____	24. Material Supplied ☐ Glass ☐ Plastic ☐ Oversized ☐ Tint #__ ☐ Pair ☐ 1/2 Pair ☐ Other _____	

25. Type of lenses dispensed	26. If contact lenses, please complete	27. Professional Service	Amount
☐ None	☐ Therapeutic	Lens Charge	$
☐ Single	☐ Non-Therapeutic	Frame Charge	$
☐ Bifocal	☐ Hard Lenses	Optional Lens	$
☐ Trifocal	☐ Soft Lenses	Optional Frame	$
☐ Lenticular		Disp. Fee Lens	$
☐ Contacts		Disp. Fee Frame	$
☐ Sunglasses		Sales Tax (if any)	$
☐ Other (specify below)		Total	$
		Amount Paid By Patient	$

28. 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

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. **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.

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.

Please Retain A Copy For Your Records