



Vision Benefits Request – Refractive Eye Exam



TO BE COMPLETED BY EMPLOYEE				
1. Employer's Name COSTCO WHOLESALE CORPORATION			2. Policy/Group Number Branch Number 701143	
3. Employee's Social Security Number		4. Employee's Name		5. Employee's Birthdate (MM/DD/YYYY)
6. Employee's Address (include Zip Code) <input type="checkbox"/> New Address			7. Employee's Daytime Telephone Number ()	
8. Patient's Social Security Number		9. Patient's Name		10. Patient's Birthdate (MM/DD/YYYY)
11. Patient's Address (if different from Employee)			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 Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
14. 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				
15. <input type="checkbox"/> Claim payment is unassigned, PAY Member, leave signature blank below <input type="checkbox"/> Claim payment is assigned, PAY DOCTOR, complete signature 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				
16. Diagnostic Code(s): <input checked="" type="checkbox"/> Check Code or list codes and description that apply <input type="checkbox"/> V72.0 EXAMINATION OF EYES AND VISION <input type="checkbox"/> Other routine, list: _____				
17. Routine Eye Examination: Provide Exam Date, Check Procedure Code and complete the Fee Amount				
Date	<input checked="" type="checkbox"/>	CPT Code	Description	Fee
	<input type="checkbox"/>	92002	New Eye Exam & Treatment (First time patient – Intermediate exam)	
	<input type="checkbox"/>	92004	New Eye Exam & Treatment (First time patient – Comprehensive exam)	
	<input type="checkbox"/>	92012	Eye Exam & Treatment (Returning patient – Intermediate exam)	
	<input type="checkbox"/>	92014	Eye Exam & Treatment (Returning patient – Comprehensive exam)	
	<input type="checkbox"/>	92015	Determination of Refractive	
			Other:	
	<input type="checkbox"/>	92499	Eye Service or Procedure, <i>Define Service:</i>	
18. 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.			19. Patient's Account Number	20. Professional Service Amount
				Examination Charge \$
				Sales Tax (if any) \$
				Total Charge \$
				Amount Paid by Patient \$
21. Doctor/Supplier Signature I hereby certify that the procedures as indicated by the 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. Signature _____ Date _____			22. Doctor/Supplier Name & Address (include zip code)	
23. Title <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> O.D.			24. Doctor/Supplier Telephone Number ()	

Send the completed form to: **Aetna Life Insurance Company**
P.O. Box 14586
Lexington, KY 40512-4586