Reimbursement Request under COVA HealthAware

Commonwealth of Virginia

Customer Control # 863637

Member Name: _____

Member Address: _____

Member Phone#: _____

Member DOB: _____

Member ID#: _____

Date Submitted: _____

Premium Reimbursement Request: ___ Yes ___ No

*Supply Copy of Premium Reimbursement Paid Receipt

Out of Pocket Reimbursement Request: ___ Yes ___ No

*Supply Copy of Explanation of Benefits from other Insurance Carrier showing Member Responsibility (i.e. Copay, Deductible, Coinsurance) COVA HealthAware

Claim Mailing Address or Fax#:

aetna®

Fax#: 959-333-2001

For Internal Use Only: ECHS EXMP PLAN