DOCUMENTATION TO SUPPORT FLU VACCINATION RECEIVED OUTSIDE OF THE STATE HEALTH BENEFITS PROGRAM IN ORDER TO RECEIVE COVA HEALTHAWARE "DO-RIGHT" HRA CREDIT

COVA HealthAware Participant's Name:	
Date of Birth:	
ID Number:	

Please indicate which option you wish to use to report your flu vaccination and provide the requested documentation.

☐ **Option 1:** Attach documentation which must include:

- Name of individual receiving the vaccine
- Date of vaccination
- Name of provider (e.g. facility, contractor)
- Name and title of health care provider administering the vaccine

☐ **Option 2:** Have the following information completed by the health care provider administering your flu vaccine:

Date flu vaccine was administered to the above-named health plan participant: _____

Name of provider/facility/contractor:_____

Signature and title of health care provider administering the vaccine:

_____ _____ _____

Signature Title Date

I certify that the information on this form or attached to this form is correct to the best of my knowledge.

Signature of COVA HealthAware Participant:

_____ _____

Signature Date

NOTE: Please allow 30 days for your "Do-Right" credit to be funded in your HRA.

Fax completed form to:
959-282-1293