

**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:	
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:

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

Date

NOTE: Please allow 60 days for your “do-right” credit to be funded in your HRA.
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Send completed form to:
Do-Right Flu Shot Coordinator
DHRM – Office of Health Benefits
101 North 14th Street, 13th Floor
Richmond, VA 23219
Fax: 804-371-0231