



## 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®**

P.O. Box 981106

El Paso, TX 79998-1106

Fax#: 859-455-8650