



**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:

\_\_\_\_\_

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

<b>NOTE: Please allow 30 days for your "do-right" credit to be funded in your HRA.</b>
--

**Fax completed form to:  
(959) 333-2659**