

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

For Internal Use Only: ECHS EXMP PLAN

Fax#: 859-455-8650