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 I: 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.

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