COVA
Request for Reimbursement

Instructions

1. Employee must complete Employee Information.

2. Complete Claim Information in its entirety. Please ensure your supporting documentation clearly indicates the requested amount.

3. Check the appropriate box in Supporting Documentation section and attach Acceptable Supporting Documentation as described below. (When attaching small receipts, we suggest you tape them to a standard size sheet of paper.)
   a) Itemized Statement or bill from your provider including:
      • Provider name
      • Patient name
      • Description of service
      • Original date of service (the date of service, not the date of payment must fall within the plan year for which you are enrolled and while you are a participant in the plan)
      • Patient portion of charge(s); or
   b) Explanation of Benefits (EOB) from your insurance carrier; or
   c) Pharmacy Statement including:
      • Patient name
      • Prescribing physician
      • RX number
      • Name of the drug
      • Date the RX was filled
      • Co-payment amount

*Unacceptable Documentation includes the following:
   • Cancelled Checks
   • Credit / cash receipts (An itemized cash register receipt is acceptable for eligible over-the-counter expenses)
   • Balance forward statements

4. Sign and date Employee Certification.

5. Submit Claims To:
   Anthem Blue Cross and Blue Shield
   Fax: 888-347-5212 Phone: (877) 451-7244
   P.O. Box 660165
   Dallas, TX 75266-0165

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.
# Request for Reimbursement

## Employee Information

<table>
<thead>
<tr>
<th>Account Number</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**E-mail Address (if not on file)**

<table>
<thead>
<tr>
<th>Email Address</th>
</tr>
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<tbody>
<tr>
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</table>

### Category*

<table>
<thead>
<tr>
<th>Category</th>
<th>Medical</th>
<th>Dental</th>
<th>Rx</th>
<th>Vision</th>
<th>Ortho</th>
<th>OTC</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

### Patient Information

<table>
<thead>
<tr>
<th>Patient First Name</th>
<th>Date of Service (MM/DD/YY)</th>
<th>Requested Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$</td>
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