Aetna Better Health® of Virginia

Member Reimbursement Request Form for Non-Traditional Indian Medicine

(Must be a federally recognized tribe in VA)

Medallion 4.0 Enhanced Benefit

IMPORTANT:

- * Always allow up to 30 days from form submission time, until you receive the response (to allow for mail time and claims processing time)
- * Keep a copy of all documents submitted for your records
- * You must include a copy of receipts. Do not staple or tape receipts to this form.
- * Maximum reimbursement amount is $200.00 per year

Member Information/This Section must be fully complete to ensure proper reimbursement of you claim

____   _____________________

Member Medicaid # (please write legibly)   **Today's Date (Month, Day, Year)**

__________________________ , _________________

Members Last Name,   First Name

____

Member Address, City, State, Zip-Code

____________________________   ____________________________

Purchase Date of Enhanced Benefit Item(s)   Reimbursement Amount Requested

____

Item name(s) or description of item(s) purchased for reimbursement

This Section to be filled out by Health Plan Representative

Total Amount approved: ___________   Pay To: ____________________________

____

Member **MAILING** Address, City, State, Zip-Code **(*only if different than above)**

Approver's Name___________________________   Aetna ID #_____________________

Notice

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment. I certify that I(or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

____   ________________

Signature of Plan Participant   Date

Please email from to: VAMEDICAIDMEMBERSERVICES@AETNA.COM
If not able to email, please mail to:
Aetna Better Health of VA, Member Services
9881 Mayland Drive
Richmond, VA 23233