Aetna Better Health® of Virginia
PO Box 818044
Cleveland, OH 44181-8044

Aetna Better Health® of Virginia

Member Reimbursement Request Form for Native Medicine

For federally-recognized tribes in Virginia

Important:

- You must include a copy of receipts; do not staple or tape receipts to this form.
- Provide proof of Indian or Alaska Native tribal membership by including one of the following:
  - Copy of Certificate of Degree of Indian or Alaska Native Blood from the Bureau of Indian Affairs
  - Copy of Tribal Enrollment Card, ID, or document from a federally recognized Indian or Alaska Native tribe, band, nation, pueblo, village, or community of which you are a member
- Always allow up to 30 days from form submission time until you receive the response. This is to allow for mail time and claims processing time.
- Keep a copy of all documents submitted for your records.
- Maximum reimbursement amount is $200 per year.

Member Information

This section must be fully complete to ensure proper reimbursement of your claim.

Member's Medicaid ID number:		**Date:**
Member's last name:	**Member's first name:**	
Member address:		
City:	**State:**	**ZIP:**
Purchase date of enhanced benefit item(s):		
Reimbursement amount requested:		
Item name(s) or description of item(s) purchased for reimbursement:		

This section is to be filled out by health plan representative.

Total amount approved:	**Pay to:**
Approver name:	**Aetna ID number:**

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:**

Email your completed form to VAMedicaidMemberServices@Aetna.com.

Or, mail to:
Aetna Better Health of Virginia
ATTN: Member Services
PO Box 818044, Cleveland, OH 44181-8044