Denver Health Medical Plan, Inc.
Member Reimbursement Form

Member's Name: ____

Mailing Address: ____

Member's I.D. Number: ____

SHOE ORTHOTICS:
__________ L3000
$100.00 Maximum benefit per calendar year

HEARING AID:
__________ V5100
$1500.00 every 5 years, if 18 years of age or older
Under age 18, covered at 100%

Please NOTE: All necessary receipts must be submitted with reimbursement request.

Mail Claims to: Denver Health Medical Plan
Attn: Claims Department
P.O. Box 24992
Seattle, WA 98124-0992