DENVER HEALTH & HOSPITAL AUTHORITY (DHHA)
MEMBER REIMBURSEMENT FORM

Member Full Name: ____________________________________________________________

Member Mailing Address: _______________________________________________________

Member Health Plan I.D. Number: ________________________________________________

OPTICAL BENEFITS (for plans that offer this benefit):

- Eyewear ($350.00)
  Note: Only one claim can be submitted in a 24-month period; i.e. if you are using
  the benefit for contacts, you may want to wait until you have accumulated $350
  in charges before submitting a claim in order to use full benefit.

- Lasik Eye Surgery – 65760 ($200.00)
  Note: This benefit can be used at any time regardless of whether or not the
  $350/24-month benefit has been used. Once per lifetime benefit.

SHOE ORTHOTICS:

- L3000 ($100.00)
  Note: Maximum benefit per calendar year; deductible must be met.

HEARING AID:

- V5100 ($1500.00 every 5 years, if 18 years of age or older)
  Note: Under age 18, covered at 100%

IMPORTANT: Receipts must be submitted with reimbursement request.

MAIL TO: Denver Health Medical Plan
          Attn: Claims Department
          P.O. Box 24631
          Seattle, WA 98124