DENVER HEALTH & HOSPITAL AUTHORITY (DHHA)
MEMBER REIMBURSEMENT FORM

Member Full Name: ______________________________

Member Mailing Address: ______________________________

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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%

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IMPORTANT: Receipts must be submitted with reimbursement request.

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