2021 MEDICARE MEMBER REIMBURSEMENT FORM

Member's Name: ____

Mailing Address: ____

Member's I.D. Number: ____

VISION BENEFIT (for contact lenses and eyeglasses - frames and lenses):

- ☐ $200 plan coverage limit every calendar year

HEARING AID BENEFIT:

- ☐ $1,500 plan coverage limit for hearing aids every three (3) years

MISCELLANEOUS:

- ☐ Out-of-Network Emergency or Urgent Care expense
- ☐ Miscellaneous – List
  1. ____
  2. ____
  3. ____

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

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