ELEVATE MEDICARE ADVANTAGE
Denver Health Medical Plan Inc.

2022 MEDICARE MEMBER REIMBURSEMENT FORM

Member's Name: _____
Mailing Address: _____
Member's I.D. Number: _____

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

- ☐ $250 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.