ELEVATE
MEDICARE ADVANTAGE
Denver Health Medical Plan Inc.™

2023 ELEVATE MEDICARE ADVANTAGE MEMBER REIMBURSEMENT FORM

Member Full Name: ____

Member Mailing Address: ____

Member Health Plan ID Number: ___________________________________

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

- ❑ $250 plan coverage limit every calendar year (Elevate Medicare Choice D-SNP Plan)
- ❑ $200 plan coverage limit every calendar year (Elevate Medicare Select HMO Plan)

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. ____

IMPORTANT: All necessary receipts must be submitted with this reimbursement request.

MAIL TO:
Denver Health Medical Plan
P.O. Box 6300
Columbia, MD 21045