



## ELEVATE HEALTH PLANS MEMBER REIMBURSEMENT FORM

Member Full Name: \_\_\_\_\_

Member Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Member Health Plan ID Number: \_\_\_\_\_

### CONTRACEPTIVES:

- Over-the-Counter Oral Contraception
- Over-the-Counter Emergency Contraception

### MISCELLANEOUS:

- Other \_\_\_\_\_

**IMPORTANT:** Receipts/proof of payment, proof of visit (including diagnosis and CPT codes with date of services for all services performed), along with your name, home mailing address and member ID number must be submitted with this request.

### MAIL TO:

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