DENVER HEALTH AND HOSPITAL AUTHORITY (DHHA)
MEMBER REIMBURSEMENT FORM

Member Full Name: _____

Member Mailing Address: _____

_____

Member Health Plan ID Number: _____

Member Date of Birth (MM/DD/YYYY): _____ / _____ / _____

OPTICAL BENEFITS:

☐ **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. The date(s) of service for requested reimbursement cannot be within 24 months of your last requested reimbursement date(s) of service.

☐ **Lasik Eye Surgery – 65760 ($200.00)**
Note: This benefit can be used at any time regardless of whether the $350/24-month benefit has been used. Once per lifetime benefit.

SHOE ORTHOTICS:

☐ **L3000 ($100.00)**
Note: Maximum benefit per calendar year.

HEARING AID:

☐ **V5100 ($1500.00 every 5 years, if 18 years of age or older)**
Note: Under age 18, covered at 100%.

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