ELEVATE HEALTH PLANS
MEMBER REIMBURSEMENT FORM

Member Full Name: _____

Member Mailing Address: _____

_____

Member Health Plan ID Number: _____

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

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