ELEVATE MEDICARE ADVANTAGE
Denver Health Medical Plan Inc.

2025 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):

- ❑ $245 plan coverage limit every calendar year
  (Elevate Medicare Choice D-SNP Plan)
- ❑ $220 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 (Please include procedural and diagnosis codes if available):

- ❑ Out-of-Network Emergency or Urgent Care expense
- ❑ Miscellaneous (List)
  1. _____
  2. _____
  3. _____

IMPORTANT: All necessary receipts must be submitted with this reimbursement request. You must submit your claim to us within 12 months of the date you received the service or item.

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