

Vision, hearing aid allowance and/or over the counter (OTC) reimbursement form

Use this form to file a claim for reimbursement of out of pocket costs of covered eyewear, hearing aids and/or OTC plan benefits (if applicable). *Do not use this form for post-cataract eyewear reimbursement requests.*

Member's name _____
Last name, First name

Member ID # _____

Member's address _____

Street address _____

City _____ State _____ Zip code _____

Eyeglasses or contact lenses:

Business name _____ **Phone** _____

Address _____

Street address _____

City _____ State _____ Zip code _____

Total amount paid \$ _____ **Date of service** _____

Hearing aids:

Business name _____ **Phone** _____

Address _____

Street address _____

City _____ State _____ Zip Code _____

Total amount paid \$ _____ **Date of service** _____

OTC:

Business name _____ **Phone** _____

Address _____

Street address _____

City _____ State _____ Zip Code _____

Total amount paid \$ _____ **Date of service** _____

Send this completed form with an itemized receipt for each purchase to:

ConnectiCare Claims Department

P.O. Box 4000

Farmington, CT 06034-4000

Retain a copy of your claim submission for your own records.

ConnectiCare[®]

connecticare.com/medicare