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