Capital Health PLAN℠
An Independent Licensee of the Blue Cross and Blue Shield Association

Capital Health Plan
Reimbursement Request Form

Member Requesting Reimbursement Name: _____ _____ _____
Last *First* *Middle Initial*

Member ID: _____ Member DOB: _____

Telephone Number: _____

Note: If approved, your reimbursement will be sent to the subscriber. The subscriber is the health plan policyholder. If you need to update your address, please contact Member Services. **Medicare Members**, please call 850-523-7441 or 1-877-247-6512. **State of Florida Members**, please call 1-877-392-1532. **All other Members**, please call 850-383-3311 or 1-877-247-6512.

Type of Reimbursement (Please select one):

☐ **Eyeglasses** (*applies to Medicare Plans only - $150 limit every 2 years*):
Please attach an itemized receipt which includes the following information: member name, date, facility name, list of items/ services purchased, and total amount paid.

☐ **Eyeglasses** (*After Cataract Surgery - limitations apply*):
Please attach an itemized receipt which includes the following information: member name, date, facility name, list of items/ services purchased, and total amount paid.

Cataract Surgery Facility: _____ **Cataract Surgery Date:** _____

☐ **Other**:
Please explain in detail the service you received or items you purchased and your reason for requesting reimbursement. (*There are separate forms for Prescription Drug Reimbursement and Health/Fitness Reimbursement*.)

_____
_____
_____
_____
_____
_____

Additional Information:

_____
_____
_____
_____

Please include each item and check off the boxes below:

☐ This completed form.

☐ Clear copies of all receipts, bills, and/or itemized statements pertaining to request (explained above).

Reimbursement requests must be submitted to Capital Health Plan within one year from the date of service. Reimbursement requests can take up to 30 days to process. It may take longer if additional information is needed to process the request.

Mail completed form to:
Capital Health Plan
Claims Department
Po Box 15349
Tallahassee, FL 32317-5349

_____ _____
Member/Subscriber Signature Date