MEMBER REIMBURSEMENT REQUEST FORM

MEMBER INFORMATION

Member name:		ID Number:
Name of member's DCR* or guardian (if applicable):		
Address:		
City:	State:	Phone:

*designated client representative

DESCRIBE WHY YOU HAD TO PAY OUT OF POCKET AND THE SERVICE OR PRODUCT THAT WAS PROVIDED *(if needed, write on the back of this form or add another page)*

YOUR REQUEST CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.
Please include all itemized receipts or your request may be delayed.

MAIL TO
Colorado Access/Access Health Colorado
PO Box 17950
Denver, CO 80217-0580

To speak with someone directly, call 1-877-276-5184. TTY/TDD users call 1-888-803-4494.

coaccess.com
1-800-511-5010

accesshealthco.com
1-855-325-9426

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