

Town of Wellesley HRA Claim Voucher

THIS FORM MUST BE FILED BY JANUARY 31 FOR THE PREVIOUS CALENDAR YEAR EXPENSES

CPA, INC.
420 Washington Street, Suite 100
Braintree, MA 02184

(781) 848-9848 (Phone)
(781) 848-8477 (Fax)

EMPLOYEE: _____ SS#: _____ - _____ - _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: () _____ E-MAIL: _____

Reimbursement for subscriber and family members enrolled in Rate Saver health plan.

EXPENSES MUST BE OCCURRED BETWEEN JANUARY 1 AND DECEMBER 31

Type Of Medical Care Expense	Reimbursable Co-Pay Amount	Number (visits, admissions, incidents, or prescriptions)	Total Reimbursement (Number times reimbursable amount)
<i>Example: Office Visit-Specialist Care Co-pay</i>	\$20 per visit	2	\$40
Office visit—Specialist Care	\$20 per visit		
Emergency Room Visit (not admitted)	\$25 per visit		
In-patient admission	\$150 per admission		
Same-day Surgery	\$75 per incident		
Diagnostic Imaging	\$50 per incident		
Prescription drug—Retail	\$10 for each prescription of \$25 or more		
Prescription drug—Mail Order	\$20 for each prescription		

TOTAL CLAIM AMOUNT: \$ _____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the Town of Wellesley Health Reimbursement Arrangement. I have not been reimbursed from any other source including insurance programs or other programs offered by my employer. None of these expenses have previously been submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. I hereby request reimbursement for these claims. **All medical claims submitted require copies of original invoices or receipts.**

PARTICIPANT'S SIGNATURE: _____ DATE: _____