Town of Ashland
Health Reimbursement Arrangement (HRA)

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

info@cpa125.com
(781) 848-8477 (Fax)
(781) 848-9848 (Phone)

EMPLOYEE: _____ **SS#: xxx - xx -** _____

ADDRESS: _____**CITY:**_____

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

Reimbursement for subscriber and family members enrolled in GIC health plans.

EXPENSES MUST BE OCCURRED BETWEEN JULY 1, 2017 TO JUNE 30, 2018

Type of Medical Care Expenses **Eligible CO-PAYS**	**Co-Pay Amount**	**Dates Of Services**	**Number** (of visits, admissions, incidents, or prescriptions)	**Total Reimbursement** (Number times co-pay amount)
Office Visit /Primary Care				
Office visit—Specialist Care				
Emergency Room Visit				
In-patient hospitalization				
Same-day Surgery				
Diagnostic imaging				
Physical Therapy				
Prescription drugs—Retail				
Prescription drugs—Mail Order				

TOTAL CLAIM AMOUNT: $_____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the Town of Ashland 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 receipts.**

PARTICIPANT'S SIGNATURE: _____ **DATE**: _____