

**Town of Ashland
Health Reimbursement Arrangement (HRA)**

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

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(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, 2016 TO JUNE 30, 2017

Type of Medical Care Expenses	Co-Pay Amount	Dates Of Services	Number (of visits, admissions, incidents, or prescriptions)	Total Reimbursement (Number times co-pay amount)
Eligible CO-PAYS				
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: _____