TOWN OF WELLESLEY
HUMAN RESOURCES DEPARTMENT

HRA REIMBURSEMENT FORM

All forms must be returned to: CPA, INC.
420 Washington Street, Suite 100
Braintree, MA 02184
Phone: (781) 848-9848 Fax: (781) 848-8477

Name: Social Security #:

Address: City/Town:

State: Zip: Phone:

Email Address:

This form must be filed by January 31 for the previous calendar year expenses.
Expenses must be incurred between January 1 and December 31.

Type of Medical Care Expense	Reimbursable Co-Pay Amount	Number of uses	Total Reimbursement
Example: Specialist Office Visit	*$20 per visit*	*2*	*$40*
Office visit – Specialist ($35 or more)	$20 per visit		
Urgent Care / Minute Clinic	100% of co-pay		
Primary Care Physician	$10 per visit (max. 3 per year)		
Inpatient Admission	$150 per admission		
Same Day Surgery	$75 per incident		
Diagnostic Imaging	$50 per incident		
Prescription Drug – Retail	$10 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.**

Signature Date