Town of Wellesley Health Reimbursement Arrangement Claim Form
THIS FORM MUST BE FILED BY JULY 31, 2019

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 the Benchmark Health Insurance plans.

MEDICAL CARE CO-PAYMENTS UP TO $300 INDIVIDUAL OR $750 FAMILY

EXPENSES MUST BE OCCURRED BETWEEN JULY 1, 2018 TO JUNE 30, 2019

Type Of Medical Care Expense	**Reimbursable Co-Pay Amount**	**# of Co-payments**	**Dates of Service**	Total Reimbursement (Number times reimbursable amount)
Example:		*2*	*1/1+5/31*	*$40*
Office visit—Specialist Care $35+	$25 per visit			
Urgent Care (No ER Co-payments)	$10 per visit			
In-patient admission	$200/$400 per admission			
Same-day Surgery	$100 per incident			
Diagnostic Imaging	$50 per incident			
Mail Order Prescriptions $75+	$25 per 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**: _____

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