Town of Wellesley Health Reimbursement Arrangement non-Medicare Retiree 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 Benchmark Health Insurance plans.

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

HRA PLAN #1 - MEDICAL CARE COPAYMENTS (UP TO $200 INDIVIDUAL OR $300 FAMILY)

Type Of Medical Care Expense	Reimbursable Co-Pay Amount	#	Dates of Service	Total Reimbursement
Example:		*2*	*1/1+5/31*	*$50*
Specialist Office Visit ($35+)	$25 per visit			
Urgent Care (NO ER)	$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 AMOUNT: $_____

HRA PLAN #2 DEDUCTIBLE EXPENSES ONLY (UP TO $150 INDIVIDUAL OR $450 FAMILY)

Check one: Individual: ☐ Family : ☐

Date of Service:	Provider	Type of Service	Amount

TOTAL 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 claims require a copy of your Explanation of Benefits/Claim Summary from the insurance company along with a completed claim form.**

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