

Town of Wellesley Health Reimbursement Arrangement Claim Form
THIS FORM MUST BE FILED BY JULY 31, 2020

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 INCURRED BETWEEN JULY 1, 2019 TO JUNE 30, 2020

Type Of Medical Care Expense	Reimbursable Co-Pay Amount	# of Co-payments	Dates of Service	Total Reimbursement (Number times reimbursable amount)
<i>Example:</i>		2	1/1+5/31	\$50
Office visit—Specialist Care \$60+	\$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 (MRI, CAT SCANS, PET SCANS)	\$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: _____