

**Town of Brookline
Health Reimbursement Arrangement (HRA) Voucher
JULY 1, 2018 TO JUNE 30, 2019**

CPA, INC.
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Braintree, MA 02184

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(781) 848-9848 (Phone)

EMPLOYEE: _____ SS#: _XXX_ - _XX_ - _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: () _____ E-MAIL: _____

NAME OF MEMBER INCURRING THE CLAIM: _____

Reimbursement for subscriber and family members enrolled in
Non-Medicare group health plans through the GIC/Town of Brookline.
ALL EXPENSES MUST BE INCURRED BETWEEN JULY 1, 2018 THROUGH JUNE 30, 2019.

Type of Medical Care COPAY Expenses	Co-pay charged	Reimbursable Amount	Date of Service/ Bill Date	Total Reimbursement
<i>Example: ER co-pay</i>	<i>\$100.00</i>	<i>\$50.00</i>	<i>7/25/18</i>	<i>\$50</i>
Out-patient Day Surgery		\$150.00		
Inpatient Hospital Admission		\$500.00		
Emergency Room		\$50.00		
High-Tech Imaging		\$100.00		

TOTAL CLAIM AMOUNT: \$ _____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's co-payment 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, receipts or claim summaries from your insurance company. Eligible co-payment for reimbursement include: up to \$150 for out-patient day surgery co-pays, up to \$500.00 for inpatient hospital admission co-pays, \$50.00 for Emergency Room co-pays and \$100.00 for High-Tech imaging co-pays (MRI, CT scan, PET scan) for members requiring three or more high-tech imaging services that result directly from a serious and/or chronic medical condition. Reimbursements will be on the 3rd high-tech imaging co-pay.

PARTICIPANT'S SIGNATURE: _____ DATE: _____