TOWN OF IPSWICH
Health Reimbursement Account (HRA) Claim Form
Plan Year: July 1, 2017 – June 30, 2018

Cafeteria Plan Advisors, Inc.
420 Washington Street, Suite 100
Braintree, MA 02184
(781) 848-9848 (Phone)
(781) 848-8477 (Fax)
info@cpa125.com (Email)

EMPLOYEE: _____ **SS#: xxx -xx -** _____

MAILING ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____ **DAY TIME PHONE: ( )** _____

EMAIL: _____

HRA Reimbursement for eligible active employees & family members enrolled in the Network Blue New England HMO or the Blue Care Elect PPO Plan Health Plans for the following expenses:

HRA #1

- HOSPITAL ADMISSION / IN-STAY COPAY - $300 or $700

HRA #2

- AMBULATORY OUTPATIENT DAY SURGICAL COPAY - $150
- EMERGENCY ROOM COPAY - $100
- HIGH TECH IMAGING (MRI, PET, CT, Nuclear Cardiac Scans) COPAYS - $100
- MENTAL HEALTH HOSPITAL & SUBSTANCE ABUSE FACILITY COPAY - $200

Date of Service:	Name of Eligible Member Incurring Expense:	Type of Service (Hospital Copay or High Tech Imaging):	Amount to be Reimbursed:
_____	_____	_____	$_____
_____	_____	_____	$_____
		TOTAL:	$_____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's Health Reimbursement Account Plan. 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 the Explanation of Benefits/Claim Summary from the insurance company detailing the expense. All payments are paid to the participant. Claims are paid within 30 days. Expenses must be submitted no later than 30 days after the plan year ends (July 31). However, expenses incurred under the HRA#2 reimbursements are available only until the budgeted funds are exhausted.

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