

**Town of Brookline
Health Reimbursement Arrangement (HRA) Voucher
JULY 1, 2016 TO JUNE 30, 2017**

CPA, INC.
420 Washington Street, Suite 100
Braintree, MA 02184
(781) 848-9848 (Phone)

info@cpa125.com
(781) 848-8477 (Fax)

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, 2016 THROUGH JUNE 30, 2017.

Type of Medical Care COPAY Expenses	Co-pay charged	Reimbursable Amount	Date of Service/ Bill Date	Total Reimbursement
<i>Example: ER co-pay</i>	\$100.00	\$50.00	7/25/16	\$50
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.

PARTICIPANT'S SIGNATURE: _____ DATE: _____