

CPA, INC.  
420 Washington Street, Suite 100  
Braintree, MA 02184  
(781) 848-8477 (Fax)

**CLAIM VOUCHER**

Address change

Go to [www.cpa125.com](http://www.cpa125.com) for additional forms/information

EMPLOYER: \_\_\_\_\_

EMPLOYEE: \_\_\_\_\_ SS#: XXX - XX- \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

**UNREIMBURSED MEDICAL EXPENSES (Participants & Eligible Dependents -as defined by the IRS guidelines)**

ITEMS (group similar items)	DATE OF SERVICE	AMOUNT
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
	<b>TOTAL:</b>	\$ _____

**DEPENDENT/CHILD CARE EXPENSES (daycare)**

\_\_\_\_\_ \$ \_\_\_\_\_

**TRANSPORTATION ACCOUNT EXPENSES (For Participants Enrolled in Qualified Parking/Transit Plan ONLY)**

PARKING (IRS Monthly max \$230) \_\_\_\_\_ \$ \_\_\_\_\_

TRANSIT (IRS Monthly max \$230) \_\_\_\_\_ \$ \_\_\_\_\_

**All medical claims submitted require copies of bills/statements/receipts showing date and type of service. (No cancelled checks/ credit card receipts). All claims must be received 2 days prior to claim payment day. Direct deposit payments are processed weekly (Wednesday). Checks are processed at least twice a month (every other Wednesday). Please allow 3 business days to receive your check. Minimum payment is \$20.00.**

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's Cafeteria 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. Additionally, I am aware that unused funds may be forfeited or otherwise handled in accordance with the plan document and the current IRS law. I hereby request reimbursement for these claims.

**PARTICIPANT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## CLAIM PROCESSING & PROCEDURES

- PAYMENTS: DIRECT DEPOSIT PAYMENTS ARE PROCESSED WEEKLY (WEDNESDAY).

PLEASE ALLOW TWO BUSINESS DAYS FOR FUNDS TO BE IN YOUR ACCOUNT.  
CHECKS ARE ISSUED AT LEAST TWICE A MONTH (EVERY OTHER WEDNESDAY).

- CLAIMS MUST BE RECEIVED BY MONDAY AT 5:00PM TO BE SCHEDULED FOR PROCESSING THAT WEEK.
- MEDICAL CLAIMS SUBMITTED REQUIRE COPIES OF BILLS/STATEMENTS/RECEIPTS SHOWING DATE AND TYPE OF SERVICE. (NO CANCELLED CHECKS/CREDIT CARD RECEIPTS).
- YOU MAY FAX A CLAIM AND YOUR RECEIPTS TO CPA, INC. PLEASE LIMIT TO 10 PAGES.
- ELIGIBLE EXPENSES REQUIRE THE DATE OF SERVICE FALL WITHIN YOUR PLAN YEAR, NOT WHEN YOU WERE BILLED OR PAID THE EXPENSE.
- GROUP EXPENSES TOGETHER ON ONE LINE (See Example Below)

<u>ITEMS</u>	<u>DATE INCURRED</u>	<u>AMOUNT</u>
Co-pays	1/6/11 – 5/31/11	200.00
Dental Expenses	2/28/11 – 3/15/11	750.00

<b>IRS Reimbursable Expenses (examples). Please call CPA, Inc. if any questions.</b>
--

<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Alcohol/Drug Therapy</li> <li>Bandages/Band Aids</li> <li>Birth Control Pills</li> <li>Braces (Orthodontics)</li> <li>Chiropractors</li> <li>Contact Lenses and Solution</li> <li>Co-payments for Doctor Visits</li> <li>Deductible Expenses</li> <li>Dental Fees – <u>No bleaching or veneers</u></li> <li>Dentures</li> <li>Eye Exams</li> <li>Eye Surgery (Laser)</li> <li>Gauze Pads</li> <li>Glasses (Including Non prescription)</li> <li>Hearing Aids and Batteries</li> <li>Hospital Care/Services</li> <li>Insulin and Testing Supplies</li> </ul>	<ul style="list-style-type: none"> <li>Medications</li> <li>Mileage traveled to/from a medical facility: (.19 per mile effective 2011)</li> <li>Nursing Services</li> <li>Orthopedic Inserts</li> <li>Osteopath</li> <li>Parking for Medical Care</li> <li>Prescriptions</li> <li>Prescription Sun Glasses</li> <li>Psychologist Fees</li> <li>Psychiatric Care</li> <li>Splints</li> <li>Surgical Fees</li> <li>Support Braces (Wrist/Knee/Carpal Tunnel)</li> <li>Therapy (Physical and Occupational)</li> <li>Viagra</li> </ul>
---	--



The following items require a physician prescription each plan year stating the expense is necessary to treat a particular medical condition/disease. Wellness procedures and programs are NOT covered.

Muscular Therapy	Weight Loss Programs (No Food)
Vitamins/Supplements	Health Club memberships



**IMPORTANT NOTE:** Effective 1/1/2011, Over-The-Counter medicines are no longer eligible expenses, unless submitted with a prescription.