

**Town of Ashland
Health Reimbursement Arrangement (HRA)**

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 Rate Saver health plans.

EXPENSES MUST BE OCCURRED BETWEEN October 1, 2011 TO JUNE 30, 2012

Type of Medical Care Expense	Co-Pay Amount	Number (visits, admissions, incidents, or prescriptions)	Total Reimbursement (Number times co-pay amount)
<i>Eligible CO-PAYS</i>			
Office Visit /Primary Care			
Office visit—Specialist Care			
Emergency Room Visit			
In-patient hospitalization			
Same-day Surgery			
Diagnostic imaging			
Physical Therapy			
Prescription drugs—Retail			
Prescription drugs—Mail Order			

TOTAL CLAIM AMOUNT: \$ _____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the Town of Ashland 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 receipts.**

PARTICIPANT'S SIGNATURE: _____ DATE: _____