

**Barnstable County
Health Reimbursement Arrangement (HRA)
Claim Voucher
JULY 1, 2010 TO JUNE 30, 2011**

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 JULY 1, 2010 TO JUNE 30, 2011

Type Of Medical Care Expense	Reimbursable Co-Pay Amount	Number (visits, admissions, incidents, or prescriptions)	Total Reimbursement (Number times reimbursable amount)
<i>Example: Office Visit Co-pay</i>	<i>\$10 per visit</i>	<i>3</i>	<i>\$30</i>
All Office Visit Copays & Other Medical Care Expenses Subject to the Primary Care Co-pay	\$10 per visit		
Office visit—Specialist Care	\$10 per visit		
Emergency Room Visit (not admitted)	\$25 per visit		
In-patient admission	\$300 per admission		
Same-day Surgery (excludes colonoscopy)	\$200 per incident		
Prescription drug—Retail	\$10 for each prescription		
Prescription drug—Mail Order	\$20 for each prescription		

TOTAL CLAIM AMOUNT: \$ _____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the Barnstable County 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 original invoices or receipts.**

PARTICIPANT'S SIGNATURE: _____ DATE: _____