

HRA/Co-payment Reimbursement Voucher

CPA, INC.
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Braintree, MA 02184
(781) 848-9848 (Direct)
(781) 848-8477 (Fax)

Go to www.cpa125.com for additional forms

EMPLOYER: _____

EMPLOYEE: _____ SS#: _____ - _____ - _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: () _____

NAME OF MEMBER INCURRING THE CLAIM _____

REIMBURSEMENT (Subscriber & Family Members enrolled in Group Health plan)

PROVIDER	Type of Service (Inpatient/Office co-pay)	Date of Service	AMOUNT
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
TOTAL:			\$ _____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's Co-payment Reimbursement Policy. 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. All claims must be received 3 days prior to claim payment day. Claims are processed the last day of each month. Please allow 3 business days to receive your check.

PARTICIPANT'S SIGNATURE: _____ DATE: _____