# Town of Wellesley Health Reimbursement Arrangement
## Claim Voucher
**JANUARY 1, 2010 TO DECEMBER 31, 2010**

**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 plan.

**EXPENSES MUST BE OCCURRED BETWEEN JANUARY 1, 2010 TO DECEMBER 31, 2010**

| **Type Of Medical Care Expense** | **Reimbursable Co-Pay Amount** | **Number (visits, admissions, incidents, or prescriptions)** | **Total Reimbursement** (Number times reimbursable amount) |
|---|---|---|---|
| ***Example:*** *Office Visit Co-pay* | *$5.00 per visit* | *3* | *$15* |
| All Office Visit Co-pays & Other Medical Care Expenses Subject to the Primary Care Co-pay | **2010: $5 per visit** | | |
| Office visit—Specialist Care | $20 per visit | | |
| Emergency Room Visit (not admitted) | $25 per visit | | |
| In-patient admission | $150 per admission | | |
| Same-day Surgery | $75 per incident | | |
| Diagnostic Imaging | $50 per incident | | |
| Prescription drug—Retail | $10 for each prescription of $25 or more | | |
| 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 Town of Wellesley 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**: ________________