

HRA
Health Reimbursement Voucher

CPA, INC.
420 Washington Street, Suite 100
Braintree, MA 02184
(781) 848-9848 (Phone)
(781) 848-8477 (Fax)

EMPLOYER: **YMCA Cape Cod**

EMPLOYEE: _____ SS#: _____ - _____ - _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: () _____

NAME OF MEMBER INCURRING THE CLAIM _____

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

Service Date	Provider (Hospital/Medical Facility)	Type of Service	AMOUNT
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
TOTAL:			\$ _____

Instructions:

- **Submit this form along with copies of your eligible medical expenses (bills/statements/receipts) showing the date and type of service. (No cancelled checks).**
- **All claims must be received 2 days prior to claim payment day. Direct deposit payments are processed weekly (on Wednesday), and are usually in your account the next day. Checks are processed at least twice a month (every other Wednesday). Please allow at least 3 business days to receive your check.**
- **Claims can be mailed to the above address or faxed to 781-848-8477.**

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's Reimbursement 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. I hereby request reimbursement for these claims.

PARTICIPANT'S SIGNATURE: _____ DATE: _____