TOWN OF MEDWAY
HEALTH REIMBURSEMENT ARRANGEMENT
REIMBURSEMENT REQUEST FORM

Name		
Home Address	Address Change: Yes____ No___	
City	State	Zip
Phone: Work ( ) Home/Cell ( )	Email:	

Complete the information below for expenses incurred by you, your spouse, or dependent children for which you request reimbursement. You must provide the Carrier's **Explanation of Benefits (EOB)** as evidence the expenses were incurred. Allowable expenses are as follows:

1. Inpatient Co-Pay (Maximum $300 per admission)
2. Outpatient Surgical Procedures Co-Pay (Maximum $250 per occurrence)
3. Hospital Emergency Room Co-Pay (Maximum $100 per occurrence)
4. Deductible Expenses (Maximum $300 for Individual Subscribers and $600 for Family Subscribers) For the deductible expense please submit your request after you receive the Explanation of Benefits noting that you have satisfied either the individual or family deductible. Be sure to provide all information requested on this form. Incomplete forms will be returned to you. Print or type the information requested, sign and date the form. Mail or fax this form and supporting documentation to the below contact. *****The Town will not process deductible reimbursements unless the deductible has been satisfied*****

HRA MEDICAL EXPENSES INCLUDE: Prescription drug co-pays, over certain limits during the Fiscal Year					
	Provider of Service (hosp, surg facility, etc.)	Person Receiving Service	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Actual Expense (number 1-4 from above list)
1					
2					
3					
4					

I request payment from my health reimbursement account as indicated above for the expenses listed. To the best of my knowledge and belief, my statements in this reimbursement request are complete and true. I am claiming reimbursement only for eligible expenses incurred during the plan year and for my eligible dependents. I certify that these expenses have not previously been reimbursed under this or any other benefit pan and will not be claimed as an income tax deduction. I authorize my Health Reimbursement Arrangement account to reimburse me the amount requested.

Employee Sgnature_____Date_____
Submit claim and expense documentation to:

Human Resources
Town of Medway
155 Village Street
Medway, MA 02053