

**TOWN OF IPSWICH**  
**Health Reimbursement Account (HRA) Claim Form**  
**Plan Year: July 1, 2021 – June 30, 2022**

Cafeteria Plan Advisors, Inc.  
 420 Washington Street, Suite 100  
 Braintree, MA 02184  
 (781) 848-9848 (Phone)  
 (781) 848-8477 (Fax)  
[info@cpa125.com](mailto:info@cpa125.com) (Email)

**EMPLOYEE:** \_\_\_\_\_ **SS#:** xxx-xx-\_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_

**STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **DAY TIME PHONE:** (     ) \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

***HRA Reimbursement for eligible retirees or active employees & family members enrolled in the Network Blue New England HMO or Blue Care Elect PPO Health Plans for the following expenses:***

**HRA #1**

- HOSPITAL ADMISSION / IN-STAY COPAY - \$300 or \$700

**HRA #2**

- AMBULATORY OUTPATIENT DAY SURGICAL COPAY - \$150
- EMERGENCY ROOM COPAY - \$100
- HIGH TECH IMAGING (MRI, PET, CT, Nuclear Cardiac Scans) COPAYS - \$100
- MENTAL HEALTH HOSPITAL & SUBSTANCE ABUSE FACILITY COPAY - \$200

Date of Service:	Name of Eligible Member Incurring Expense:	Type of Service (Hospital Copay or High Tech Imaging):	Amount to be Reimbursed:
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
<b>TOTAL:</b>			\$ _____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's Health Reimbursement Account 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.

***All medical claims submitted require copies of the Explanation of Benefits/Claim Summary from the insurance company detailing the expense.*** All payments are paid to the participant. Expenses must be submitted no later than **30** days after the plan year ends (July 31). However, expenses incurred under the HRA#2 reimbursements are available only until the budgeted funds are exhausted.

**PARTICIPANT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_