# TOWN OF IPSWICH
# Health Reimbursement Account (HRA) Claim Form
# Plan Year: July 1, 2022 – June 30, 2023

Cafeteria Plan Advisors
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**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: |
|---|---|---|---|
| _____ | _____ | _____ | $_____ |
| _____ | _____ | _____ | $_____ |
| | | **TOTAL:** | $_____ |

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**: _____