Dennis-Yarmouth Regional Schools- Health Reimbursement Arrangement (HRA)
Claim Voucher ~ **JULY 1, 2016 TO JUNE 30, 2017**
*****All expenses must be submitted no later than July 30, 2017.***

Cafeteria Plan Advisors, Inc.
420 Washington Street, Suite 100
Braintree, MA 02184

(781) 848-9848 (Phone)
(781) 848-8477 (Fax)
info@cpa125.com (Email)

EMPLOYEE: _____ **SS#: XXX - XX -** _____

ADDRESS: _____**CITY:**_____

STATE: _____ **ZIP:** _____**PHONE: ( )** _____**E-MAIL:** _____

Expenses for subscriber and family members enrolled in the health plans must be incurred between 7/1/16 – 6/30/17

Type of Medical Expense	☐ Blue Cross ☐ Harvard Pilgrim	Reimbursable Co-pay Amount	Quantity #	Dates of Services	Total Reimbursement (number x amount)
Example: Office Co-pay		**$10 per visit**	**3**		**$30**
All office co-pays, physical therapy, chiropractic, and other office visits deemed necessary by the member's Primary Care Physician or Specialist	$20.00 per visit	$10 per visit			
Office visit – Specialist	$35 per visit	$25 per visit			
ER Visit (not admitted)	$100 per visit	$25 per visit			
In-patient	$500 per admission	$200 per admission			
Same-day surgery	$150 incident (waived for all colonoscopies)	$100 per incident			
Prescription drug – Retail Co-pays	Tier 2 - $25 Tier 3 - $50 Non formulary	$10 for each prescription with co-pay of $25 or more			
Prescription drug – Mail Order Co-pays	Tier 1 - $20 Tier 2 - $50 Tier 3 - $110	$20 each prescription			
Plan Year Deductible *Requires a claim summary as a receipt*	$250 Indiv $750 Family	$125 max Indiv $375 max Family			

TOTAL CLAIM AMOUNT: $_____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the 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 the claim summaries from your insurance company.**

PARTICIPANT'S SIGNATURE: _____ **DATE**: _____