



All forms must be returned to: CPA, INC.
420 Washington Street, Suite 100
Braintree, MA 02184
Phone: (781) 848-9848 Fax: (781) 848-8477

Name: _____ Social Security #: _____

Address: _____ City/Town: _____

State: _____ Zip: _____ Phone: _____

Email Address: _____

**This form must be filed by January 31 for the previous calendar year expenses.
Expenses must be incurred between January 1 and December 31.**

Type of Medical Care Expense	Reimbursable Co-Pay Amount	Number of uses	Total Reimbursement
<i>Example: Specialist Office Visit</i>	<i>\$20 per visit</i>	<i>2</i>	<i>\$40</i>
Office visit – Specialist (\$35 or more)	\$20 per visit		
Urgent Care / Minute Clinic	100% of co-pay		
Primary Care Physician	\$10 per visit (max. 3 per year)		
Inpatient Admission	\$150 per admission		
Same Day Surgery	\$75 per incident		
Diagnostic Imaging	\$50 per incident		
Prescription Drug – Retail	\$10 each prescription of \$25 or more		
Prescription Drug – Mail Order	\$20 for each prescription		

Total Claim Amount: \$ _____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the Town of Wellesley 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 original invoices or receipts.**

Signature _____ Date _____