TOWN OF WINCHESTER
HEALTH REIMBURSEMENT ARRANGEMENT
REIMBURSEMENT REQUEST FORM

*Must be submitted to HR Department within 90 days of paid bill

Name		
Home Address	Address Change: Yes____ No____	
City	State	Zip
Work Phone Home/Cell	Email	
Department _____ Union _____ Non-Union _____	Current Employee _____ Retiree _____	

FILING INSTRUCTIONS

Please complete this form to request reimbursement for expenses incurred by you or your insured dependents. Reimbursement is limited to the copayments listed below. **In addition to this completed form, you must provide an itemized bill, a receipt or other evidence of payment, and a copy of your BC/BS Activity Summary.** Please be sure to provide all documentation requested as missing information will cause a delay in processing your request. Mail or deliver this completed request and required documentation to: Human Resources, Town of Winchester, 71 Mt. Vernon Street, Winchester, MA 01890.

BCBS NE HMO and Elect PPO co-pays eligible for reimbursement:

Inpatient Hospitalization:	$300 per admission
Outpatient Surgery	$150 per visit
Hi-tech Radiology Services	$100 per test (CT scan, PET scan, MRI and MRA)
Emergency Room Visit:	$100 per visit

HRA MEDICAL EXPENSES INCLUDE:
co-pays for inpatient hospitalization, outpatient surgery, hi-tech radiology services or emergency room visit

	Provider of Service (hosp, surg facility)	Person Receiving Service	Date(s) of Service (MO/DAY/YR)	Amount of Expense Claimed	Service Provided
1					
2					
3					
4					

I request payment from the Town's 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 for myself and/or my eligible dependents. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize the Town to reimburse me the amount requested from the Health Reimbursement Arrangement Account.

Employee Signature_____Date_____