

# Healthcare Reimbursement Account CLAIM FORM

Submit To: Asst. Town Manager/Human Resources Director  
 Town of Westborough  
 34 West Main Street  
 Westborough, MA 01581

**For internal use only:**

Approved by: \_\_\_\_\_

(Revised June 2011)

Employee Name	Check one: <input type="checkbox"/> Town Employee <input type="checkbox"/> School Employee <i>Please note that Retirees are not eligible for HRA funds.</i>
Department	
Employee Address (Street, City, ST, Zip)	
Employer Name <b>Town of Westborough</b>	Health Plan
Patient Name	Relationship of Patient to Employee
Is claim for a dependent child age 19 or older, please indicate	Is Dependent a full-time student? YES <input type="checkbox"/> NO <input type="checkbox"/>
Date of Service:	

## Healthcare Reimbursement Amount Requested

Inpatient:	\$150.00	X	_____	= \$	_____
Outpatient:	\$100.00	X	_____	= \$	_____
Emergency Room:	\$50.00	X	_____	= \$	_____
Imaging (MRI, PET, CAT Scan):	\$75.00	X	_____	= \$	_____

**Total Amount Requested: \$ \_\_\_\_\_**

**Employees will be reimbursed through payroll. Payment will be non-taxable.**

To avoid delays in processing this claim, please attach itemized statements which include:

- Patient's Name
- Date of Service
- Type of Co-payment (inpatient, outpatient, imaging or Emergency Room)
- Amount charged
- Proof of payment\*

(\*Proof of Payment can be a copy of credit card receipt, copy of a cancelled check, or a paid receipt from provider.)

**I hereby certify that I have paid the above requested amount for members covered under my health plan.**

**Date: \_\_\_\_\_ Employee Signature: \_\_\_\_\_**

**Any person who knowingly and with intent to defraud any benefit plan or insurance company, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.**