



Address: P.O. Box 1300, Manchester, NH 03105

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**Town of Needham Health Reimbursement Arrangement (HRA)  
Claim Voucher  
JULY 1, 2013 TO JUNE 30, 2014**

Employee: \_\_\_\_\_ SS#: \_\_\_\_\_  
(only last 4 digits)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Health Plan: Network Blue NE**

This reimbursement is for subscriber and family members enrolled in a "Rate Saver" Health Plan.  
 All expenses must be incurred between July 1, 2013 to June 30, 2014.

A	B	C	D	E	F
Type of Medical Care	Amount Charged	Reimbursable Amount	Number of visits, incidents, or prescriptions	Total Reimbursement (C x D)	Amount to be applied participant's FSA (B - C) x D
<i>Ex: Office Visit</i>	\$15	\$10	3	$\$10 \times 3 = \underline{\$30}$	$\$15 - \$10 = \$5 \times 3 = \underline{\$15}$
Office Visit Tier 1	\$15	\$10			
Tier 2	\$25	\$20			
Tier 3	\$45	\$40			
Office Visit Specialist/Vision	\$45	\$40			
ER Visit Copay	\$100	\$75			
Inpatient Tiers	\$250/\$500	\$250/\$500			
Day Surgery Tiers	\$150/\$250	\$150/\$250			
Diagnostic Imaging Tiers	\$75/\$150	\$75/\$150			
Rx-Retail Tier 1	\$15	\$10			
Rx-Retail Tier 2	\$30	\$20			
Rx- Retail Tier 3	\$50	\$25			
Rx-Mail Order Tier 1	\$30	\$25			
Rx-Mail Order Tier 2	\$60	\$50			
Rx-Mail Order Tier 3	\$100	\$75			
<b>Total HRA Reimbursement Amount</b>				<b>\$</b>	
<b>Total FSA Reimbursement Amount</b>					<b>\$</b>

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the Town of Needham 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.

**All medical claims submitted require copies of original invoices or receipts.**

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_