Address: P.O. Box 1300, Manchester, NH 03105 **Phone:**(888) 401-3539 **Fax:** (603) 647-4668

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: Fallon SelectCare & Direct Care EPO Rate Saver

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
Ex: Office Visit	*$20*	*$15*	*3*	*$15 x 3= $45*	*$20-$15= $5 x 3= $15*
Office Visit Copay	$20	$15			
Office Visit Specialist Copays	$40	$35			
ER Visit Copay	$75	$50			
Inpatient Copay	$250	$250			
Same Day Surgery Copay	$125	$125			
Diagnostic Imaging	0	0			
Rx-Retail Tier 1	$10	$5			
Rx-Retail Tier 2	$25	$10			
Rx- Retail Tier 3	$45	$10			
Rx-Mail Order Tier 1	$20	$10			
Rx-Mail Order Tier 2	$50	$20			
Rx- Mail Order Tier 3	$90	$0			
			Total HRA Reimbursement Amount	**$**	
				Total FSA Reimbursement Amount	**$**

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:** _____