TOWN OF MEDWAY
HEALTH REIMBURSEMENT ARRANGEMENT
REIMBURSEMENT REQUEST FORM - FY27

Name		
Home Address	Address Change: Yes_____ No____	
City	State	Zip
Phone: Work ( ) Home/Cell ( )	Email:	

Complete the information below for expenses incurred by you, your spouse, or dependent children in **Fiscal Year 2027** for which you request reimbursement. You must provide the Carrier's **Explanation of Benefits (EOB)** as evidence the expenses were incurred in FY27 and claimed no later than July 31st of the following Fiscal Year. This benefit is available to **active** employees and dependents covered by the Town-sponsored Health Plan. Allowable expenses are as follows:

1. Inpatient Co-Pay (Maximum $300 per admission)
2. Outpatient Surgical Procedures Co-Pay (Maximum $150 per occurrence)
3. Hospital Emergency Room Co-Pay (Maximum $100 per occurrence)
4. Deductible Expenses (Maximum $250 for Individual Subscribers and $500 for Family Subscribers) For the deductible expense please submit your request after you receive the Explanation of Benefits noting that you have satisfied either the individual or family deductible.

Be sure to provide all information requested on this form. Incomplete forms will be returned to you. Print or type the information requested, sign and date the form. Submit this form and supporting documentation to the below contact. *****The Town will not process deductible reimbursements unless the complete deductible has been satisfied**Rates are based on the negotiated HMO side letter dated 3/16/2017.***

HRA MEDICAL EXPENSES INCLUDE:
Deductibles, ER co-pays, Outpatient surgical copays, or Inpatient co-pays

	Provider of Service (hosp, surg facility, etc.)	Person Receiving Service	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Actual Expense (number 1-4 from above list)
1					
2					
3					
4					

I request payment from the 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 current plan year and for my eligible dependents. I certify that these expenses have not previously been reimbursed under this or any other benefit pan and will not be claimed as an income tax deduction.

Employee Signature_____Date_____
Submit claim and expense documentation to:

Human Resources
Town of Medway
155 Village Street
Medway, MA 02053