Town of Middleborough

Co-Pay Health Reimbursement Form
(Retiree supplemental plans)

Effective January 1, 2013-June 30, 2013

All reimbursements are due by the 15th of the following month. (Jan 2013-Mar 2013) due by April 15th, (Apr 2013-June 2013) due by July 15th.

EMPLOYEE NAME: _____
HOME ADDRESS: _____
CITY, STATE AND ZIP: _____

DEPARTMENT/RETIRED FROM: _____

(Reimbursed Amount)

Tier 3 **Retail** Prescription: _____ @ $15.00 per prescription $_____
(# of prescriptions)

Tier 3 **Mail Order** Prescriptions: _____ @$30.00 per prescription $_____
(# of prescriptions)

Total Reimbursement: $_____

YOU MUST SUBMIT THE ORIGINAL RECEIPT WHICH SHOULD INCLUDE YOUR NAME, NAME OF PHARMACY, DATE OF REFILL AND TOTAL AMOUNT PAID.

FOR OFFICE USE ONLY

DATE_____ WARRANT_____

INVOICE_____

ACCT.NO. 01.951.475201.0.0 ACCT.NAME: **RETIREE HEALTH INSURANCE MITIGATION FUND**

VENDOR_____ VOUCHER_____

AMOUNT_____ APPROVED BY_____