TOWN OF MIDDLEBOROUGH
CO-PAY HEALTH REIMBURSEMENT FUND

***** PLEASE NOTE CHANGES TO PROCEDURE EFFECTIVE JULY 1, 2017**

Co-Pay Health Reimbursement Form

Summary of Changes:

Starting next quarter July 1, 2017 through September 30, 2017, you will be required to submit a Summary of Benefits ONLY, which can be obtained by logging into your GIC Health Insurance Website. The Summary of Benefits should be printed out for each month within the quarter AND for every member of your family. You are only to submit the Summary of Benefits form with your Co-Pay Health Reimbursement Form.

WE WILL NO LONGER BE ACCEPTING RECEIPTS.

If you have any questions, please call Sue Powers at 508-946-2420 X1127

Quarterly Reimbursements will be accepted up until the second week of the following months:

OCTOBER (includes July 1 - September 30)
JANUARY (includes October 1 - December 31)
APRIL(include January 1 - March 31)
JULY (include April 1 - June 30)

Send all information Sue Powers, Treasurers and Collectors Office/Bank Building

Middleboro Health Insurance Reimbursement Rules 2015 AND Middleboro Application Form

Reimbursement requests shall be submitted within 15 days of the end of the quarter, which shall be January 1, April 1, July 1, and October 1.
Any single reimbursement request of $300 or above shall be processed upon receipt.
Reimbursement requests shall be submitted on a form developed by the Treasurer

	DAY SURGERY	MRI CT PET SCANS	HIGH COST HOSPITAL	LOWER COST HOSPITAL	SPECIALISTS	EMERGENCY ROOM	TIER 3 DRUGS MAIL ORDER	TIER 2 DRUGS MAIL ORDER
Co-Pay Effective 7/1/2015	$250.00	$100.00	$1,500.00	$275.00 or 500.00	$30/$60/$90	$100.00	$165.00	$75.00
Reimbursement	$150.00	$75.00	$1,100.00	$75.00 or $300.00	$0/30/60	$50.00	$90.00	$25.00
Cost to Employee	$100.00	$25.00	$400.00	$200.00	$30.00	$50.00	$75.00	$50.00

See Next Page For Printable Form

Fill out shaded fields then print and mail the form to the Treasurers Office.

Print Form

Town of Middleborough

NEW Co-Pay Health Reimbursement Form

Effective July 1, 2015

QUARTERLEY REIMBURSEMENTS WILL BE ACCEPTED UP UNTIL THE **SECOND WEEK** OF THE FOLLOWING MONTHS: **OCTOBER** (July 1-Sept 30) **JANUARY** (Oct 1-Dec 31) **APRIL** (Jan 1-March 31) AND **JULY** (April 1-June 30).

EMPLOYEE NAME:_____

HOME ADDRESS:_____

CITY, STATE AND ZIP:_____

DEPARTMENT/OFFICE:_____

Day Surgery: _____ @ $150.00 per visit = $_____
visits

MRI, CT, PET Scans:_____ @ $75.00 per visit = $_____
scans

High Cost Hospitals:_____ @ $1,100.00 per admission = $_____
# of admissions

Low Cost Hospitals:_____ @ $75.00 or $300.00 per admission = $_____
# of admissions

Specialists: _____ @ $30.00 or $60.00 per visit $_____
(Depends on Tier)

Emergency Room: _____ @ $50.00 per visit = $_____

Tier 2 Drugs: _____ @ $25.00 per prescription $_____

Tier 3 Drugs: _____ @ $90.00 per prescription $_____

Total Reimbursement: $_____

YOU MUST SUBMIT THE ORIGINAL RECEIPT WHICH SHOULD INCLUDE THE DOCTOR'S/HOSPITAL'S NAME AND ADDRESS, DATE OF SERVICE AND TOTAL AMOUNT PAID.

ANY REIMBURSEMENT REQUEST OF $300 OR ABOVE SHALL BE PROCESSED UPON RECEIPT.

DATE:_____ **WARRANT**_____

INVOICE: _____

ACCT. NO: 01.951.465201.0.0 **ACCT. NAME:** EMPLOYEE HEALTH INSURANCE MITIGATION FUND

VENDOR: _____ **VOUCHER**_____

AMOUNT: _____ **APPROVED BY:** _____