City of Taunton *MEDEX Prescriptions*

Health Reimbursement Form

Plan Year: 2022

Part I. Subscriber Information **☐(Check if new address)**

MEDEX #: -_____

MEDEX Subscriber's Name: _____
Last *First*

Mailing Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Phone: ( ) (home cell) Email Address:

Part II. Instructions for submitting form (Please Read Carefully)

To qualify for the reimbursement, retirees or their eligible spouses must provide proof of payment of out of pocket prescription costs totaling over **$631.97** for those individuals enrolled in MEDEX 2. The City will reimburse employees for out of pocket costs until the HRA account funds have been exhausted for the given plan year.

1. Complete Part I on this form and make sure to indicate if your mailing address has changed.

2. Complete Part III detailing member name, date of service, type of service, description of service, and amount paid. All expenses must be incurred in the plan year commencing **1/1/22** and ending **12/31/22**. **You have up to <u>30 days after the end of a plan year</u> to submit prescription co-pay expenses that are eligible for reimbursement.**

3. All **prescription co-pay receipts or invoices** supporting your request for reimbursement must be attached. This supporting documentation must show prescription number, date of prescription, amount paid, member name showing a zero ("0") balance.

4. Eligible retiree participant must sign Part IV certifying authenticity of expenses.

<u>Examples of Eligible Expenses</u>

Prescriptions: Only co-pays for prescription medications are eligible for reimbursement.

Part III. Detail of Out of Pocket Costs Prescription Costs (attach paid receipts)

Name of MEDEX Subscriber	Date of Service (mm/dy/yr)	Prescription Rx #		Amount Paid to Provider

(Additional space on back)

Part III. Detail of Out of Pocket Costs (cont.) *Make copies of this page if additional space is needed.* **Plan Year:** 2022

	Date of Service (mm/dy/yr)	Prescription Rx #		Amount Paid to Provider

Total out-of-pocket prescription co-pay costs _____

Part IV. Signature

The above statements and submitted information for reimbursement are true. I am only submitting for reimbursement for eligible expenses that I incurred for myself. I further certify that I will not claim these expenses as a tax deduction. ***Please note: All claims submitted are subject to approval by the Human Resources Department.***

Subscriber's Signature: _____ **Date:** / /

HR Office Use Only

Human Resources Department
15 Summer St
Taunton, MA 02780
Attn: Rachael (508) 821-1060

Less Employee Threshold: $ 631.97

Amount to be reimbursed: _____

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