



City of Chelsea
Human Resources
 City Hall, 500 Broadway Room 301
 Chelsea, Massachusetts 02150
 Phone 617-466-4170 Fax 617-466-4175

CO-PAYMENT REIMBURSEMENT REQUEST FORM

INSTRUCTIONS			
Please forward all completed requests for reimbursement to: Chelsea Human Resources Department, City Hall, 500 Broadway, Room 301, Chelsea, MA 02150.			
EMPLOYEE/PATIENT INFORMATION			
Employee Name:		HCHP Number:	
Patient Name:		Relationship to Employee:	
HOSPITAL/FACILITY INFORMATION AND SERVICES PROVIDED			
Name of Hospital or Facility:			
CHECK APPROPRIATE BOX		DATES	
<input type="checkbox"/>	Inpatient Hospital Stay = \$300.00	Admittance Date:	Discharge Date:
<input type="checkbox"/>	Emergency Room Visit = \$150.00	Date of Emergency Room Visit:	
<input type="checkbox"/>	High Tech Imaging (MRI, PT, CT scans) = \$50.00	Date of High Tech Imaging Visit:	
REIMBURSEMENT			
<p>I am applying for reimbursement of the above co-payment. This request is filed under the authority of the Memorandum of Agreement (the "Agreement") entered into for FY 2016 through FY 2018 between the City and the Chelsea Public Employee Committee ("PEC") for the purpose of reimbursing subscribers for the above copayments. The Reimbursement Policy of the Agreement allows for reimbursement of copayment charges as applied under the City's Harvard Pilgrim Health Care plans. Reimbursement is applicable to a maximum amount per fiscal year as specified in the Agreement. I understand this request is subject to the approval of the City of Chelsea, who shall take into consideration such factors as the availability of the annual funds committed per the Agreement, the applicable reimbursement or appropriate payment by another party and any other factors deemed relevant.</p> <p>To receive reimbursement, subscribers shall submit with their reimbursement request form evidence of payment for their co-payment amount to the Human Resources Department in the <u>same</u> fiscal year (July 1st to June 30th) of the date of the medical service event defined as an a) inpatient hospital admission or upon the subscriber's discharge (whichever is longer), b) emergency room visit or c) imaging visit, e.g., MRI, PT, CT scans. The City understands in certain circumstances, billing may not be received by the subscriber within the same fiscal year of the event. In such instances and in accordance with the Agreement, reimbursement requests with proper documentation may be submitted no later than September 30th of the fiscal year following the medical service event. IMPORTANT: The reimbursement request form must be submitted with applicable invoices and documentation establishing the co-payment has been paid for a covered subscriber; such as a cancelled check, credit card statement, or cash receipt. Reimbursement requests will be processed on a quarterly basis and payment made in the following quarter if claims are submitted no later than thirty (30) days prior to the end of the quarter.</p>			
SIGNATURE			
Employee Signature:		Date:	
FOR HUMAN RESOURCES DEPARTMENT USE ONLY			
Date Received by HR:		Received By:	
Approved By:		Date:	