City of Chelsea

Human Resources
City Hall, 500 Broadway Room 301
Chelsea, Massachusetts 02150

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CO-PAY REIMBURSEMENT REQUEST

PLEASE FORWARD ALL REQUESTS FOR REIMBURSMENTS TO:
Human Resources Department
City Hall, 500 Broadway, Chelsea, MA 02150 Room 301

Employee Name _____ HP number _____

Name of patient _____ Relationship: _____

Name of Hospital or Facility _____

☐ Inpatient Hospital Stay - $300.00 Beginning Date of In-Patient Hospital Stay_____
Admitted_____ Discharged _____
☐ Emergency Room Visit - $150.00 Date of Emergency Room Visit _____
☐ High Tech Radiology - $50.00 Date of High Tech Radiology Visit _____

I am applying for reimbursement of the above marked copayment charged This application is filed under the authority of the agreement that was entered into during FY 2016 between the City and the Chelsea Public Employee Committee for the purpose of reimbursing subscribers for the above copayments incurred throughout the duration of the aforementioned agreement. The Reimbursement Policy of the agreement allows for reimbursement of copayment charge as applied under the City's Harvard Pilgrim Health Care plans. Reimbursement is applicable to a maximum amount per fiscal years as specified in the agreement.

In order to receive reimbursement, subscribers shall submit evidence of payment for their co-payment amount to the Group Benefits Strategies within 90 days of a hospital admission or upon the subscriber's discharge, whichever is longer, ER visit or Imaging visit. I understand that this request is subject to the approval of the City of Chelsea who shall take into consideration such factors as the availability of the funds committed per the agreement, the applicable reimbursement or payment appropriate by another party (ies) and any other factors deemed relevant.

Reimbursement will be made in the following quarter if claims are submitted no later than 30 days prior to the end of the quarter.
IMPORTANT: This request must be submitted with the invoices and documentations, with appropriate identifying information shown, establishing that the copayment has been <u>paid</u> for a covered subscriber.

Employee signature _____ Date _____

FOR CITY OF CHELSEA, HUMAN RESOURCES DEPARTMENT USE ONLY

Date Received By GBS: _____ _____ by: _____
Approved _____ Date _____