Administered By:

Town of Oxford
Office of the Treasurer/Collector
Town Hall – 325 Main Street
Oxford, MA 01540
(508) 987-6038

HRA CLAIM FORM

PLEASE PRINT CLEARLY

EMPLOYEE NAME:	CHECK PLAN DESIGN: Fallon SEL __ Fallon DIR __ Fallon PPO __ Tufts __
EMPLOYEE ADDRESS (STREET, CITY, STATE, ZIP):	
IMPORTANT NOTICE →	TO AVOID DELAYS IN PROCESSING YOUR MEDICAL CLAIMS, PLEASE ENCLOSE ITEMIZED STATEMENTS WHICH INCLUDE DATE OF SERVICE, TYPE OF SERVICE, AMOUNT CHARGED, AND PATIENT'S NAME AND A COPY OF *HEALTH BENEFITS STATEMENT* (EXPLANATION OF BENEFITS) FROM FALLON OR TUFTS HEALTH PLAN THAT SHOWS YOUR DEDUCTIBLE AMOUNTS MET.
Any person knowingly and with intent to defraud any benefit plan or insurance company, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.	
By signing this form, I hereby authorize the Town of Oxford to make covered payments directly to the employee/member. It is solely the responsibility of the employee/member to make any outstanding payment directly to the provider.	
SIGNATURE OF EMPLOYEE	DATE

Maximum Plan Reimbursement Amount –$500 of the $1,000 Individual Plan Deductible
Maximum Plan Reimbursement Amount –$1,000 of the $2,000 Family Plan Deductible

PROVIDER/SUPPLIER NAME	SERVICE DATE	PATIENT NAME/RELATIONSHIP	AMOUNT
			$
			$
			$
			$
			$
		TOTAL	$