HRA CLAIM FORM

Administered By:
Treasurer's Office
Town of Northborough
63 Main Street
Northborough, MA 01532
508-393-5047

Employee Name	Date of Service

Employee Address (Street, City, ST, Zip)

Employer Name	HMO Plan
Town of Northborough	FCHP

Patient Name	Date of Birth	Relationship of Patient to Employee

IMPORTANT NOTICE	TO AVOID DELAYS IN PROCESSING THE ATTACHED MEDICAL REIMBURSEMENT, PLEASE ENCLOSE STATEMENTS WHICH INCLUDE DATE OF SERVICE, NAME OF SERVICE PROVIDER, AMOUNT OF EXPENSE, AND PATIENT'S NAME.

Any person who 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.

I hereby authorize the Town of Northborough to reimburse the employee/retiree named above for the amount of the inpatient, outpatient, or high-tech imaging co-pay for services listed on the attached bill.

Signature of Employee	Signature of Patient (if not Employee) or Parent, if minor	Date