

CPA, INC.
 420 Washington Street, Suite LL8
 Braintree, MA 02184
 (781) 848-9848
 (781) 848-8477 (Fax)

Please check if address changed

CLAIM VOUCHER

EMPLOYER: _____
 EMPLOYEE: _____ SS#: _____ - _____ - _____
 ADDRESS: _____ CITY: _____
 STATE: _____ ZIP: _____ PHONE: (_____) _____

UNREIMBURSED MEDICAL EXPENSES (Participants & Dependents)

ITEMS	DATE INCURRED	AMOUNT
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
	TOTAL:	\$ _____
DEPENDENT/CHILD CARE EXPENSES		
_____	_____	\$ _____
_____	_____	\$ _____
OTHER ACCOUNT EXPENSES		
_____	_____	\$ _____
_____	_____	\$ _____

This is to certify that I have incurred the expenses listed above which qualify for reimbursement under my employer's Cafeteria Plan, and I have not been reimbursed from any other source including insurance programs or any other program offered by my employer and none of these expenses have been previously submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. Additionally, I am aware that unused funds may be forfeited or otherwise handled in accordance with the plan document and the current IRS law. I hereby request reimbursement for these claims.

All medical claims submitted require copies of receipts. Minimum claim amount is \$50.00. All claims must be received 1 day prior to claims day. Claims are processed on the 15th and the last day of each month. Please allow 3 business days to receive your payment.

PARTICIPANT'S SIGNATURE: _____ DATE: _____




CLAIM PROCESSING


- **PAYMENTS (CHECKS OR DIRECT DEPOSIT) ARE ISSUED ON THE 15TH AND LAST DAY OF THE MONTH, IF THESE DATES FALL ON A WEEKEND OR HOLIDAY THEY ARE ISSUED THE NEXT BUSINESS DAY.**
- **ALL CLAIMS MUST BE RECEIVED PRIOR TO THE CLAIMS DAY TO BE ELIGIBLE FOR PAYMENT.**
- **YOU MAY FAX A CLAIM AND YOUR RECEIPTS TO CPA, INC. PLEASE LIMIT TO 10 PAGES.**
- **ALL EXPENSES MUST BE INCURRED (SERVICE DATE) DURING THE PLAN YEAR, IT IS NOT WHEN YOU WERE BILLED OR PAID THE EXPENSE.**
- **YOU MAY GROUP EXPENSES TOGETHER ON ONE LINE (See Example Below)**

<u>ITEMS</u>	<u>DATE INCURRED</u>	<u>AMOUNT</u>
Co-pays	1/6/05 – 5/31/05	200.00
Dental Expenses	2/28/05 – 3/15/05	750.00

IRS Reimbursable Expenses (examples). Please call CPA, Inc. if any questions.

Acupuncture
 Alcohol/Drug Therapy
 Birth Control Pills
 Braces (Orthodontics)
 Chiropractors
 Co-payments for Doctor, Dental
 Contact Lenses and Solution
 Dental Fees – no bleaching
 Dentures
 Eye Exams and Glasses
 Eye Surgery (Laser)
 Handicapped/Hearing Impaired/Sight Impaired/Learning Disabled – call CPA, Inc. for details
 Health Club - medically necessary 
 Hearing Aids and Batteries
 Hospital Care/Services
 Insulin and Testing Supplies

Muscular Therapy 
 Mileage – (.15 per mile 2005)
 Nursing Services
 Orthopedic Shoes
 Osteopath
 Prescriptions
 Psychologist Fees
 Psychiatric Care
 Physical Therapy
 Surgical Fees
 Therapy (Physical and Occupational)
 Viagra
 Vitamins  - medically necessary
 Weight Loss Programs  medically necessary
 Over the counter – Medications

 Requires a physician prescription each plan year stating the expense is necessary for a particular medical condition/disease.

Cafeteria Plan Advisors, Inc.
 420 Washington St Suite LL8
 Braintree MA 02184
 Phone: 781-848-9848 Fax : 781-848-8477

Print Form