

Town of Seekonk

Co-Pay Reimbursement Form

Employee/Subscriber Name: _____

Plan
(HMO New England or Blue Care Elect): _____

Date of Service: _____

***Reimbursement request must be submitted
within 2 weeks of Date of Service.***

Claim Type: _____ Emergency Room Co-Pay

 _____ Office Visit Co-Pay

 _____ Inpatient Co-Pay

Mailing Address for Reimbursement:

Process to reimburse employees/subscribers for
inpatient hospital co-pay and differences
for Emergency Room & Office Visit Co-pays

Employees/subscribers **must** send an original receipt
for the co-pay along with the co-pay reimbursement
form attached to:

Maureen Leary
Group Benefits Strategies
15 Midstate Drive, Suite 110
Auburn, MA 01501

Reimbursements will apply for services received from
July 1, 2007 to June 30, 2008.

***Reimbursement request must be submitted
within 2 weeks of Date of Service.***

Checks will be processed in approximately
7 to 10 working days after receipt.

Any questions please call Maureen at GBS
at 800-229-8008, ext. 11.

Thank you.