TOWN OF MARSHFIELD
OFFICE OF THE TREASURER COLLECTOR
870 MORAINE STREET
MARSHFIELD, MA 02050
Tel: (781) 834-5582, Fax: (781) 834-5583

HEALTH INSURANCE MITIGATION FUND CLAIM FORM

RECEIPT MUST BE ATTACHED – SUBMISSION TO TREASURER'S OFFICE MUST BE RECEIVED WITHIN 30 DAYS OF PAYMENT OF CO-PAY.

Step 1: Your Information

Name: _____

Mailing Address: _____

_____

Co-pay incurred by ☐ subscriber ☐ dependent (provide name)_____

Step 2: Circle your Plan

Rate Saver Plans
BCBS Network Blue HMO

BCBS Blue Care Elect PPO

Harvard Pilgrim HMO

Benchmark Plans
BCBS Network Blue NE HMO

BCBS Blue Care Preferred PPO

Harvard Pilgrim ChoiceNet HMO

Step 3: Circle the Co-pay To Be Reimbursed:

$150 Outpatient Surgical (max amount for all plans)

$250 Hospital Admission (max amount for all plans)

Step 4: Sign & Date the Claim Form

_____ _____
Signature Date

REIMBURSEMENTS WILL BE ISSUED WITHIN 30 DAYS OF RECEIPT OF COMPLETED CLAIM FORM.