**Medicare B Reimbursement Form**

Name: _____

Address: _____

Address: _____

City, State, Zip: _____

Tel. #: _____

Email: _____

I am requesting a Medicare B reimbursement from the Town of Holbrook, Massachusetts for the quarter ending **(circle one):**

3/31 6/30 9/30 12/31

My current monthly Medicare premium is $_____ and my current monthly Medicare penalty is $_____.

**Please check one of the following:**

____ My status (i.e. married, single, divorced, eligibility, etc.) has not changed since last quarter.

____ My status has changed (including address changes):

_____

_____

_____

**Submit by email or mail to:**

Email: dmcardle@holbrookmassachusetts.us

Town of Holbrook
Assistant Treasurer
50 North Franklin Street
Holbrook, MA 02343

_____ _____

Medicare Recipient Signature Date