Request for Reimbursement

from your FSA for Health Care Expenses

What is this form for?

Use this *Request for Reimbursement* form to ask for payment from your FSA for eligible care you've already received.

Get your money back faster. Submit your expenses online.

You can skip this form and easily submit your expenses online for faster reimbursement. Plus, it reduces errors and saves paper. Here's how:

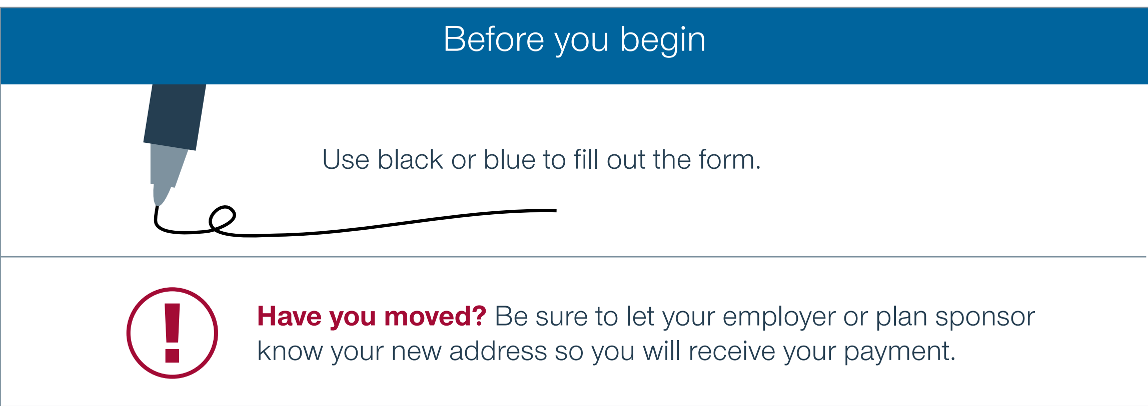
1. Log in to your account at myuhc.com.
2. Go to the Claims & Accounts tab.
3. Follow steps to submit a claim form.

Why submit online?

- Your form is instantly submitted for review.
- You can also sign up for email/text alerts to track payments.

What expenses are eligible?

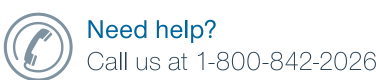
- A general list of eligible expenses and frequently asked questions is available in your FSA Benefit Book, in your account at myuhc.com or call us at 1-800-842-2026.
- **Don't miss the deadline:** Your request **must** be received **before** September 30, following the end of the plan year.



Before you begin

Use black or blue to fill out the form.

Have you moved? Be sure to let your employer or plan sponsor know your new address so you will receive your payment.



Need help?
Call us at 1-800-842-2026

Please continue to the form on the next page.

Part 1: About you

Required information, please complete this section.

Your name (Last, First, MI) ______________________ United States Postal Service

Please use your United States Postal Service Employee ID Number.

Your Employee Identification Number ☐☐☐☐☐☐☐☐☐

Your Group Number 0 1 4 1 2 4 5

Your Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Your mailing address (street address, city, state, ZIP)

Part 2: About your expenses

All claims dated January 1 through March 15 will first be paid from your previous year's FSA balance (if funds are available) UNLESS you check the box. ☐ **Process claim only from current plan year funds**

1 Expense 1 **Information must match your receipt.**

Start date of care or service ☐☐ / ☐☐ / 2 0 ☐☐

End date (may be the same as start date) ☐☐ / ☐☐ / 2 0 ☐☐

Amount

Patient name

This is (check one):
- ○ Myself
- ○ My spouse
- ○ My dependent

Type of Expense (check one):
- ○ Medical
- ○ Dental
- ○ Vision
- ○ Hearing
- ○ Prescription (RX)
- ○ Over-the-Counter (OTC)
- ○ Premiums

2 Expense 2 **Information must match your receipt.**

Start date of care or service ☐☐ / ☐☐ / 2 0 ☐☐

End date (may be the same as start date) ☐☐ / ☐☐ / 2 0 ☐☐

Amount

Patient name

(check one)
- ○ Myself
- ○ My spouse
- ○ My dependent

Type of Expense (check one):
- ○ Medical
- ○ Dental
- ○ Vision
- ○ Hearing
- ○ Prescription (RX)
- ○ Over-the-Counter (OTC)
- ○ Premiums

3 Expense 3 **Information must match your receipt.**

Start date of care or service ☐☐ / ☐☐ / 2 0 ☐☐

End date (may be the same as start date) ☐☐ / ☐☐ / 2 0 ☐☐

Amount

Patient name

This is (check one):
- ○ Myself
- ○ My spouse
- ○ My dependent

Type of Expense (check one):
- ○ Medical
- ○ Dental
- ○ Vision
- ○ Hearing
- ○ Prescription (RX)
- ○ Over-the-Counter (OTC)
- ○ Premiums

Required information, please complete this section.

Please use your United States Postal Service Employee ID Number.

Your Employee Identification Number

Your Group Number
0 1 4 1 2 4 5

Part 2: About your expenses

All claims dated January 1 through March 15 will first be paid from your previous year's FSA balance (if funds are available) UNLESS you check the box. ☐ **Process claim only from current plan year funds**

4 Expense 4 **Information must match your receipt.**

Start date of care or service
__ __ / __ __ / 2 0 __ __

End date (may be the same as start date)
__ __ / __ __ / 2 0 __ __

Amount

Patient name

This is (check one):
- ○ Myself
- ○ My spouse
- ○ My dependent

Type of Expense (check one):
- ○ Medical
- ○ Dental
- ○ Vision
- ○ Hearing
- ○ Prescription (RX)
- ○ Over-the-Counter (OTC)
- ○ Premiums

5 Expense 5 **Information must match your receipt.**

Start date of care or service
__ __ / __ __ / 2 0 __ __

End date (may be the same as start date)
__ __ / __ __ / 2 0 __ __

Amount

Patient name

(check one)
- ○ Myself
- ○ My spouse
- ○ My dependent

Type of Expense (check one):
- ○ Medical
- ○ Dental
- ○ Vision
- ○ Hearing
- ○ Prescription (RX)
- ○ Over-the-Counter (OTC)
- ○ Premiums

6 Expense 6 **Information must match your receipt.**

Start date of care or service
__ __ / __ __ / 2 0 __ __

End date (may be the same as start date)
__ __ / __ __ / 2 0 __ __

Amount

Patient name

This is (check one):
- ○ Myself
- ○ My spouse
- ○ My dependent

Type of Expense (check one):
- ○ Medical
- ○ Dental
- ○ Vision
- ○ Hearing
- ○ Prescription (RX)
- ○ Over-the-Counter (OTC)
- ○ Premiums

Part 3: Attach your receipts or Explanation of Benefit forms

Now it's time to attach the papers that confirm the expenses. These can include an itemized receipt or itemized invoice from your health care provider or Explanation of Benefit (EOB) from your insurance carrier.

Provide an itemized receipt for each amount requested, or your request will be denied.

Please don't send credit card receipts, cashed checks or copies of checks. They are not acceptable receipts for reimbursement

The papers you provide as proof for your expenses **must** show specific information:

For medical expenses:

- ◯ Name and address of provider
- ◯ Amount charged
- ◯ Type of service
- ◯ Date of service
- ◯ Patient's name

For prescriptions:

- ◯ Patient's name
- ◯ Amount charged
- ◯ Date the prescription was filled
- ◯ One of these:
  - – Name of medication
  - – The National Drug Code (NDC) number
  - – The word "co-payment" printed on receipt

1. Please do not write any additional information on the receipt.
2. Use only blue or black ink. Don't use a highlighter.
3. Tape small receipts to a sheet of 8.5 x 11 blank white paper.

Part 4: Certify and sign

Please reimburse me for the expenses I am submitting on this form.
By signing below I certify (promise) that:

- ▶ The expenses for which I am requesting reimbursement from my FSA, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) as permitted under the FSA;
- ▶ These expenses have not been reimbursed before, and I will not ask for reimbursement from any other plan;
- ▶ These expenses have not and will not be claimed as a federal income tax deduction or credit; and
- ▶ To my knowledge, the statements I have made on this form are true and complete.

Employee signature ______________________

Date __ __ / __ __ / 2 0 __ __

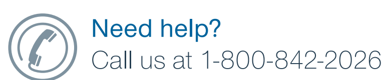
Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Mail or fax pages 2 and 4 (3 for additional expenses) of this form along with your receipts

Mail to: Health Care Account Service Center
P.O. Box 981506 El Paso, TX 79998-1506

▶ Fax: (915) 231-1709 ▶ Toll-free fax: 1-866-262-6354

Copy your form and receipts for your records before mailing.



Need help?
Call us at 1-800-842-2026

©2015 United HealthCare Services, Inc. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. M55391