UnitedHealthcare®

Health Care Reimbursement Account Claim Form

MAIL CLAIM FORM TO:
Health Care Reimbursement Account Service Center
PO Box 981506
El Paso, TX 79998-1506
Fax: 915-231-1709 Toll Free Fax: 866-262-6354
Customer Service 800-331-0480

Complete the form entirely and legibly. Your Member ID is your Social Security Number (SSN) or other Taxpayer ID.

DO

- Separate expense types by individual name.
- Complete the total request for reimbursement.
- Include provider name, address and Tax ID (Tax ID is optional).
- Send original documents or copies on white paper. Please note carbon copies and colored paper are not legible when scanned.
- Circle names and dollar amounts on receipts – especially important for OTC items.
- Tape small receipts to a standard 8.5" x 11" sheet of blank paper. Ensure print is legible.
- Attach itemized receipts/documentation to the form.
- Read Certification for Reimbursement, sign and date form.
- Make a copy of form and documentation for your personal records.

DO NOT

- Do not submit cancelled checks or credit card receipts alone. These are *not* adequate documentation without supporting itemization.
- Do not highlight names, prices or dates on receipts. They are not legible when scanned.
- Do not handwrite item names on receipts. These are not acceptable.
- Do not submit handwritten receipts for RX or OTC.
- Do not submit pre-treatment estimates or estimated insurance statements.

For **Medical and Dental** expenses, submit your insurance carrier's explanation of benefits (EOB) statement with your completed form. When applicable, your insurance claim must be finalized prior to submitting for reimbursement. For expenses not covered by your medical or dental insurance plan and for co-payments you must submit documentation which includes the following information:

* Name and Address of Provider * Dollar amount charged * Date of service * Patient's name
* Type of Service * Insurance Carrier EOB, if applicable

Prescription documentation must contain the following:

*Patient name *Out of pocket cost of the drug *Date the prescription was filled *Prescription name **or** NDC # **or** the word copay must be printed on the receipt* (Information usually can be found on prescription tags provided by pharmacies)

For non-prescription **Over-the-Counter (OTC) Drugs,** medicines, and medical care supplies check the OTC box on the claim form. Documentation must contain the following:

*Printed receipt *Name of the Over-the-Counter item *Price *Date of purchase

Starting January 1, 2011, Health Care Reimbursement Account will no longer be able to reimburse for over-the-counter (OTC) drugs and medicines, unless prescribed.

Mail (or fax) the form and required documentation to the address (or fax number) provided on this form. All reimbursement requests for a plan year must be postmarked prior to the filing deadline, which is specified in your plan documents. Please refer to your plan document for health related services that may not be covered under your specific FSA plan. For more coverage information please refer to IRS publication 502, section 213 available at www.irs.gov or by phone at 800-TAX-FORM. A general list of eligible/non-eligible items along with frequently asked questions are available on line at www.myuhc.com®.

CDHP 09-10

Bristol-Myers Squibb

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Part 1 Employee Information (Please Print) Please read the instructions in their entirety before completing form.

Employee Name (Last, First)	Member ID (SSN)	Date of Birth	Daytime Telephone No.
Mailing Address		Employer Name/FSA Number Bristol-Myers Squibb 191699	

Part 2 Health Care Expenses (Please Print) Itemize **each expense** using separate entries below. Use additional forms as necessary.

Date of Service From:	Patient Name / Relationship	Date of Birth	Description of Service	Amount
Date of Service To:	Name of Provider	Provider Phone #	Provider Address	
Type of Service[1] (Please check)		Provider Tax ID # (optional)		
MD RX OTC VIS DN HR				

Date of Service From:	Patient Name / Relationship	Date of Birth	Description of Service	Amount
Date of Service To:	Name of Provider	Provider Phone #	Provider Address	
Type of Service[1] (Please check)		Provider Tax ID #[2] (optional)		
MD RX OTC VIS DN HR				

Date of Service From:	Patient Name / Relationship	Date of Birth	Description of Service	Amount
Date of Service To:	Name of Provider	Provider Phone #	Provider Address	
Type of Service[1] (Please check)		Provider Tax ID # (optional)		
MD RX OTC VIS DN HR				

Date of Service From:	Patient Name / Relationship	Date of Birth	Description of Service	Amount
Date of Service To:	Name of Provider	Provider Phone #	Provider Address	
Type of Service[1] (Please check)		Provider Tax ID # (optional)		
MD RX OTC VIS DN HR				

[1]Please Check One Box For Each Expense Type: MD=Medical, RX=Prescription, OTC=Over-the-Counter, VS=Vision, DN=Dental, HR=Hearing

Total Request For Reimbursement	$

Certification For Reimbursement
I certify that any expenses for which I am requesting reimbursement from my Health Care Reimbursement Account, as itemized above, were incurred by me (and / or my spouse and / or eligible dependents) for medical care as permitted under the Health Care Reimbursement Account, and have not been reimbursed and I will not seek reimbursement under any other plan. I understand that expenses reimbursed through the Health Care Reimbursement Account programs cannot be used to claim any federal income tax deduction or credit. To the best of my knowledge and belief, my statements are complete and true.

EMPLOYEE SIGNATURE:_____ **DATE:** _____

Bristol-Myers Squibb