MAIL CLAIM FORM TO:

United Healthcare

PO Box 981178 HEALTH REIMBURSEMENT ACCOUNT



El Paso, TX 79998-1178

(FSA/HRA/Dependent Care Claim Form)

FLEXIBLE SPENDING ACCOUNT

Fax: (915) 781-1085; Customer Service Phone: (877) 311-7849

Complete Part 1 entirely and legibly. If you do not know your Subscriber ID, Group Number or have a change of address, please contact your benefits administrator.

Complete Part 2 if you are claiming health care expenses (medical, dental, hearing, vision, prescription or over-the-counter medications).

Complete Part 3 if you are claiming dependent care expenses. Carefully read and follow the directions below regarding the Provider's Certification of Services Rendered.

DO

- Separate expense types by individual name.
- Complete the total requested amount.
- Send original copies on white paper. 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, Dental, Vision and Hearing Expenses,** submit your insurance carriers 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, dental or vision 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 *Reason for non-coverage (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)

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

Dependent Care Services, if all four fields in the Day Care Provider's Certification section are completed, no further documentation is necessary. In lieu of the above submit a statement that includes:

*Provider's name *Provider's Tax identification or social security number *Dates of service *Cost of service

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 online at www.myuhc.com

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	First)	Subscriber ID	Date of Birth	Daytime Te	elephone No	
iling Address			Group #	Employer N	Employer Name	
Please notify your benefit admini	strator of any address chang	es.				
2 Health Care Expenses	(Please Print) itemize	each expense type using a se	parate line. Use	additional form	ıs as necessa	
	Туре	of Services				
atient's Name	Please Check One	Box Below For Each Expense Type		Of Service	Request	
	MD=Medical RX=Pr	escription OTC $=$ Over $-$ The $-$ Counter	mm/	dd/yyyy	d/yyyy Amount	
	visiv=2V	n DN=Dental HR=Hearing	F	1		
	MD□ RX □ OTO	\square VS \square DN \square HR \square	From:	То:		
	MD□ RX □ OT		From:	То:		
	MD□ RX □ OTC □ VS □ DN □ HR□		From:	То:		
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	MD RX OTO	C VS DN HR	From:	То:		
	MD□ RX □ OTO	C O VS O DN HRO	From:	То:		
Check here if you have	e an HSA (HealthCar	e Savings Account)	Health Care E	xpenses Subtotal	\$	
-		-		1.100		
t 3 Dependent Care Expe		mize each expense using a sepa Type Of Service				
				•		
Dependent's Name	Date Of Birth	i.e. Daycare, Day Camp, After School			· ·	
Dependent's Name	Date Of Birth mm/dd/yyyy	* *	mm/c	ld/yyyy	· ·	
Dependent's Name		i.e. Daycare, Day Camp, After School			· ·	
Dependent's Name		i.e. Daycare, Day Camp, After School	mm/c	ld/yyyy	· ·	
Dependent's Name		i.e. Daycare, Day Camp, After School	mm/c	To:	· ·	
Pependent's Name		i.e. Daycare, Day Camp, After School	mm/c From: From:	To:	Request Amount	
Dependent's Name		i.e. Daycare, Day Camp, After School Care	mm/c From: From: From:	To: To: To: To:	· ·	
Dependent's Name		i.e. Daycare, Day Camp, After School Care Depe	mm/c From: From: From: From:	To: To: To: To: enses Subtotal	Amount	
ay Care Provider's Certificat	mm/dd/yyyy	i.e. Daycare, Day Camp, After School Care Depe	mm/c From: From: From: From: endent Care Expended Request For	To: To: To: To: Withdrawal	Amount \$	
ay Care Provider's Certificat	mm/dd/yyyy	i.e. Daycare, Day Camp, After School Care Depe	mm/c From: From: From: From: endent Care Expended Request For	To: To: To: To: Withdrawal	Amount \$ \$	
Day Care Provider's Certificat the signer below, certify tha	mm/dd/yyyy tion of Services Rendered at the services listed in Pa	i.e. Daycare, Day Camp, After School Care Depe	mm/c From: From: From: From: endent Care Expended Request For	To: To: To: To: Withdrawal	Amount \$	
Day Care Provider's Certificat	mm/dd/yyyy tion of Services Rendered at the services listed in Pa Name: Day	i.e. Daycare, Day Camp, After School Care Depe Tot (PLEASE PRINT) art 3 above, were rendered by me ar	mm/c From: From: From: From: endent Care Expended Request For	To: To: To: To: Withdrawal	Amount \$	

by me (and/or my spouse and/or eligible dependents) for medical care as permitted under the Health Care/Dependent Care FSA, and have not been reimbursed and I will not seek reimbursement under any other plan. I understand that expenses reimbursed through the FSA program 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.

FMPI OYFF SIGNATURF	DATF.	