MAIL CLAIM FORM TO:
UnitedHealthcare
PO Box 981178
El Paso, TX 79998-1178
Fax: (915) 781-1085 Phone: (877) 311-7849

UnitedHealthcare
A UnitedHealth Group Company

FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM

Please complete the information on this form and review the following reminders:

√ Is your Participant ID number included on the form?

√ Is your Employer Name and FSA Group Number included on the form?

- You can find your FSA Group Number printed on your FSA Explanation of Benefits (EOB) or plan documents.

√ Is your total requested amount included on the form?

- Requested reimbursements should be accumulated and submitted only after they total the minimum dollar amount specified by your plan.

√ Did you attach copies of your itemized documentation with your request?

√ Did you sign and date the bottom of this form? If not, your request will be denied.

√ Have you made copies of your request for your own personal records?

The following are examples of eligible supporting documentation that should be submitted with your request. A cancelled check is **not** adequate documentation. Please note, your FSA plan may not provide reimbursement of all expenses below. Refer to your plan documents for specific terms.

Small receipts should be taped to a standard 8.5" x 11" sheet of blank paper and must be legible when scanned.

Medical, Dental, Vision and Hearing Expenses

For expenses partially covered by your medical, dental, or vision insurance plan, you must submit your explanation of benefits (EOB) statement with your completed claim form.

You may submit a copay receipt if this is your only expense.

For expenses not covered by your medical, dental, or vision insurance plan, you must submit the following information:

- Name and address of the provider
- Dates of service
- Dollar amount charged
- Patient's name
- Type of service

Prescription Drugs

The prescription name or NDC#, date the prescription was filled, patient name, and cost should be included on the receipt. This information can be usually found on the prescription tags provided by the pharmacy.

Over-the-Counter (OTC) Drugs

When submitting a receipt for an over-the-counter expense, check the RX box on the claim form. A printed receipt must include the name of the over-the-counter item, the price and the date purchased. Handwritten over-the-counter item names on register receipts are unacceptable. The name of the item(s) and price(s) must be circled on the receipt. Receipts should be taped to a standard 8.5" x 11" sheet of blank paper. Receipts must be legible when scanned.

Dependent Care Services

The Day Care Provider's Certification on the next page may be completed or a statement from the day care provider that includes the day care provider's name and tax ID or social security number, dates of service, and amount paid to the day care provider.

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FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Please read these instructions before completing your FSA withdrawal request.

1. Employee must complete **Part 1**. (If applicable, complete Part 2 "Health Care Expenses" and/or Part 3 "Dependent Care Expenses.")
2. Instructions for **Part 2**:
   A. If expenses were covered by any benefit plan, attach a **copy** of the Explanation of Benefits (EOB) along with your FSA withdrawal form. Your insurance carrier (or a spouse's carrier or an individual plan) should pay before you request an FSA reimbursement.
   B. If expenses are not covered by any benefit plan, attach a **copy** of an itemized receipt that includes the dates of service, service rendered, and total charge.
3. Instructions for **Part 3**: Request the day care provider to complete the Day Care Provider's Certification OR attach a **copy** of a receipt that includes the dates of service, day care provider's name, day care provider's tax ID or social security number and amount paid to day care provider.
4. Read the Certification For Reimbursement, **sign and date the form**. Make a **copy** for your records.
5. Mail (or fax) the form to the address (or fax number) provided on this form. All reimbursement requests for a plan year made during the following year must be postmarked prior to the filing deadline, which is specified in your plan documents.

PART 1 EMPLOYEE INFORMATION (Please Print)

EMPLOYEE NAME (Last and First)	PARTICIPANT ID	DATE OF BIRTH / /	DAYTIME TELEPHONE NO. ( ) -
EMPLOYEE ADDRESS		FSA GROUP NUMBER	EMPLOYER NAME

PART 2 HEALTH CARE EXPENSES (Please Print) Please place each expense on a separate line

PATIENT'S NAME	DATE(S) OF SERVICE MM/DD/YYYY		TYPE OF SERVICES Please check the appropriate box below for each expense(s) MD=medical RX=medicines VS=vision DN=dental HR=hearing	REQUEST AMOUNT
	From:	To:	MD☐ RX☐ VS☐ DN☐ HR☐	
	From:	To:	MD☐ RX☐ VS☐ DN☐ HR☐	
	From:	To:	MD☐ RX☐ VS☐ DN☐ HR☐	
	From:	To:	MD☐ RX☐ VS☐ DN☐ HR☐	
	From:	To:	MD☐ RX☐ VS☐ DN☐ HR☐	
			HEALTH CARE EXPENSES SUBTOTAL	**$**

PART 3 DEPENDENT CARE EXPENSES (Please Print) Please place each expense on a separate line

DEPENDENT'S NAME	DATE OF BIRTH	DATE(S) OF SERVICE MM/DD/YYYY		TYPE OF SERVICE(S)	REQUEST AMOUNT
		From:	To:		
		From:	To:		
			DEPENDENT CARE EXPENSES SUBTOTAL		**$**
			TOTAL REQUEST FOR WITHDRAWAL		**$**

Day Care Provider's Certification of Services Rendered (PLEASE PRINT)

I, the signer below, certify that the services listed in Part 3 above, were rendered by me and charges incurred have been paid for.

DAY CARE PROVIDER'S COMPANY NAME AND SIGNEE'S NAME:	DAY CARE PROVIDER'S ADDRESS:
DAY CARE PROVIDER'S TAX ID# :	DAY CARE PROVIDER'S SIGNATURE:

CERTIFICATION FOR REIMBURSEMENT

I certify that any expenses for which I am requesting reimbursement from my Health Care FSA, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) for medical care as permitted under the Health Care FSA, and have not been and will not be reimbursed by any other plan.

I certify that any expenses for which I am requesting reimbursement from my Dependent Care FSA, as itemized above, were incurred by me (and/or my spouse) for dependent care as permitted under the Dependent Care FSA, and have not been and will not be reimbursed by 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 on this form are complete and true.

Employee Signature_____**Date**_____

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