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 member website.
2. Follow steps to submit a claim form.

Why submit online?

- Your form is instantly submitted for review.
- You may be able to sign up for email alerts to track payments.

What expenses are eligible?

- A general list of eligible expenses and frequently asked questions is available on your member website.
- **Don't miss the deadline:** Your request **must** be postmarked **before** the submission deadline, which you can find in your benefits document. For help, contact your employer or plan sponsor.

Before you begin

Use **only** black or blue **pen** 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.

Please continue to the form on the next page.

UnitedHealthcare®

Need help?
Call us at 1-800-331-0480

Part 1: About you

Required information, please complete this section.

Your name (Last, First, MI)

Your employer

You can find these two numbers on your Health Plan ID Card or your member website.

Your UnitedHealthcare Member ID#

Your Group Number

Your Date of Birth

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

Part 2: About your expenses

Complete the information below for each expense you're submitting.
If you have more than three expenses, please print out multiple copies of this page.

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

Start date of care or service

End date (may be the same as start date)

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

End date (may be the same as start date)

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

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

Start date of care or service

End date (may be the same as start date)

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

Need help?
Call us at 1-800-331-0480

Please continue the form on the next page.

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 receipts from health care providers or an Explanation of Benefit (EOB) forms from your insurance plan.

Provide an itemized receipt or EOB 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 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 I am submitting were spent by me or my spouse or eligible dependents;
- These are eligible expenses;
- These expenses have not been reimbursed before, and I will not ask for reimbursement from any other account;
- 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.

Sign here _____

Date ☐☐ / ☐☐ / 2 0 ☐☐

Mail or fax pages 2 and 3 of this form along with your receipts

Mail to: Health Care Account Service Center
P.O. Box 740378 Atlanta, GA 30374

Fax: (248) 733-6148

Copy your form and receipts for your records before mailing.

Need help?
Call us at 1-800-331-0480

UnitedHealthcare®

©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. UHCEW694351-000
FSAC 8/15