UnitedHealthcare®

Claim Submission / Withdrawal Request Form

MAIL CLAIM FORM TO:
Health Care 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 Part 1 entirely and legibly. If you do not know your Member ID, Group Number or a have a change of address please contact your benefit administrator.
Complete Part 2 if you are claiming medical, dental, vision, prescription or over-the-counter (must have a prescription for eligible OTC drugs or medicines; medical supplies do not require a prescription – including insulin) medication expenses.
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.
- Include provider name, address and Tax ID (*if available*).
- Send original copies on white paper. Carbon copies and colored paper are not legible when scanned.
- Circle names and dollar amounts on receipts.
- 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.
- Do not submit pre-treatment estimates or estimated insurance statements.

For **Medical, Dental, Vision and Hearing 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, 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)

For **Eligible Over-the-Counter (OTC) Drugs or medicines** (requires a prescription to be reimbursable – other than insulin), or **Eligible OTC medical care supplies** (does not require a prescription) you must 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 *****OTC Prescription (only if OTC drug or medicine)

Dependent Care Services, if all four fields in the Day Care Provider's Certification of Services Rendered 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 information on the types of expenses that may be reimbursed please refer to IRS publication 502 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

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

Employee Name (Last and First)	Member ID	Date of Birth	Daytime Telephone No.
Mailing Address, City, State, Zip Code ***Please notify your benefits administrator of any address changes.***		Employer Name	

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 # (optional)**	
MD RX OTC VIS DN HR				

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

Part 3 Dependent Care Expenses (Please Print) itemize **each expense** using a separate line. Use additional forms as necessary.

Dependent/Child's Name	Relationship	Date of Birth mm/dd/yyyy	Type of Dependent/Child Care Service	Date(s) of Service mm/dd/yyyy		Request Amount
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
			Dependent/Child Care Expenses Subtotal			
			Total Request For Reimbursement			$

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 and Company Name:	Day Care Provider's Address:
Day Care Provider's Tax Id#:	Day Care Provider's Signature and Title:

Certification For Reimbursement
I certify that any expenses for which I am requesting reimbursement from my Health Care/Dependent 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/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.

EMPLOYEE SIGNATURE:_____ **DATE:** _____