**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 the other side of this page and review the following reminders to ensure accurate and timely processing of your request:*

- **v** Is your Participant ID number included on the form?
- **v** Is your Employer Name and FSA Group Number included on the form?

  (You can find FSA Group Number printed on your FSA Explanation of Benefits (EOB's) or Plan documents)
- **v** 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)
- **v** Did you attach copies of your itemized documentation with your request?
- **v** Did you sign and date the bottom of this form?
- **v** Have you made copies of your request for your own personal records?

The following examples are eligible for reimbursement through the Health Care Spending Account:

- Acupuncture
- Chiropractic services
- Coinsurance/Copays
- Contact lenses and solutions
- Deductibles
- Dental Expenses
- Dentures
- Diabetic supplies
- Guide dogs
- Hearing aids/batteries
- Laboratory Fees
- Laser eye surgery
- Childbirth expenses
- Orthodontia
- Pediatric services
- Prescription drugs
- Psychological treatment
- Speech therapy
- Surgical fees
- Transportation fees necessary for medical treatment
- Vaccinations
- Vision expenses

The following examples are ineligible for reimbursement through the Health Care Spending Account:

- Cosmetic procedures and supplies
- Amounts eligible for reimbursement through a separate benefit plan
- Marriage/family counseling
- Over the counter items (except contact solutions and diabetic supplies)
- Premium payments your family makes for health, dental, or vision care coverage
- Weight reduction programs for general health

The following examples are eligible for reimbursement through the Dependent Care Spending Account:

- Care for a dependent under the age of thirteen or a qualified individual incapable of self-care
- Licensed nursery schools
- Adult day care facilities
- After school programs
- Qualified child care centers
- Baby-sitters inside or outside the home while you (and your spouse) are at work. (As long as the individual is not your child and under the age of 19, or anyone you or your spouse can claim as a dependent for federal income tax purposes)

The following examples are ineligible for reimbursement through the Dependent Care Spending Account:

- Sleep away overnight camps
- Tuition fees for private or boarding homes
- 24-hour nursing home care
- Weekend or evening baby-sitting that is not necessary for you (and your spouse) to work
- Care provided for your child by a sibling under the age of 19 or someone you claim as a dependent on your income tax return
- Expenses for which you claim a tax credit on your federal income tax return

The above are some examples for eligible/ineligible expenses that can currently be reimbursed through Flexible Spending Accounts. If you have any expenses that are in question, please feel free to contact a representative at (877) 311-7849.

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# FLEXIBLE SPENDING ACCOUNT CLAIM FORM

**Please Read These Instructions Before Completing The 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**: Attach a **copy** of a receipt that includes the dates of service, day care provider's name, and amount paid to day care provider or attach a **copy** of a cancelled check from the 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=prescription 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** | **$** |

**CERTIFICATION FOR REIMBURSEMENT**

I certify that the expenses for reimbursement requested from my FSA were incurred by me (and/or my spouse and/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my FSA. I (or/we) will not use the expenses reimbursed through the FSA program as deductions or credits when filing my (our) income tax return.

**EMPLOYEE SIGNATURE:** **DATE:**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.**