UnitedHealthcare®

RETIREE PLAN CLAIM FOR REIMBURSEMENT

First Name: Last Name: SSN:

Employer Name: _____

Participant Address: _____ ☐ Address Change

ELIGIBLE HEALTH CARE EXPENSE CLAIMS

Line	Date Expense Incurred or Date of Service (Month/Day/Year)	Expense Amount Claimed	Detailed Description of Expense	Person for Whom Expense Incurred	Name of Service Provider
1	to	$.		☐ Self ☐ Spouse ☐ Child* ☐ Tax Dependent Dependent's Name:	
2	to	$.		☐ Self ☐ Spouse ☐ Child* ☐ Tax Dependent Dependent's Name:	
3	to	$.		☐ Self ☐ Spouse ☐ Child* ☐ Tax Dependent Dependent's Name:	
4	to	$.		☐ Self ☐ Spouse ☐ Child* ☐ Tax Dependent Dependent's Name:	
Total Medical Expense Claim:		$			

Please complete and submit a second form for more than 4 reimbursement requests.

* Dependent child who is less than 27 years old at the end of the tax year.

By submitting this form, I certify that: All expenses I am submitting for reimbursement were incurred: by me or another individual eligible under my company's retiree plan, which is a health reimbursement arrangement (HRA). All expenses I am submitting for reimbursement were incurred during a period I was covered by the company's retiree plan, which is an HRA. None of the expenses I am submitting for reimbursement have been reimbursed by or, if applicable to my plan, are reimbursable from any other source. I am fully responsible for the sufficiency and accuracy of information relating to the reimbursement submission, and that if an expense for which reimbursement is claimed is subsequently determined to not be an eligible expense under my plan, I may be liable for repayment to the plan and payment of all related taxes, including federal, state, or local income tax, on amounts paid from the plan. I acknowledge and agree that I have had an opportunity to consult with my tax advisor prior to submitting this form.

_____ _____

Participant's Signature Date

Attach a copy of bill, invoice or written statement, including the date of service, from a third-party supporting the request. NOTE: Provider Certification may be furnished in place of a copy of a bill. Attach a copy of any explanation of benefit statement that shows the deductible, co-insurance or amounts not covered by medical/dental plan.

MAIL OR FAX CLAIM TO: UnitedHealthcare, Attention: EV Team, P.O. Box 30516, Salt Lake City, UT 84130-0516 | Fax: 1-855-244-5016 | Phone: 1-877-298-2305 | UHCRetireeAccounts.com

SUBMITTING CLAIMS

There are several methods of submission available for your claim form and documentation:

Online - Please visit our website at UHCRetireeAccounts.com and follow the claim submission link through your login. Further instructions for claim submission are provided at the web location.

Fax - Claims may be faxed to UnitedHealthcare with documentation to 1-855-244-5016. Faxed claims received by UnitedHealthcare after 1:00 PM Central time will be considered as received on the following business day.

Mail - Claims should be sent to: UnitedHealthcare, Attention: EV Team, P.O. Box 30516, Salt Lake City, UT 84130-0516.

Regardless of your submission method, you will want to make sure you submit legible documentation. If we are unable to read items because of the quality of the copy or the fax, the claim will be denied pending resubmission of legible documentation. Supporting documentation must clearly identify:

1. **Name of person/entity providing service** (i.e. Doctors Name, Medical Facility or Clinic, Pharmacy (online or Store), Dependent Care Provider)
2. **Nature of expense** (i.e. Co-Insurance, Copay, Deductible, Medical, Vision or Dental (must specify specific reason for visit), Dependent Care (must describe care i.e. daycare, after or before school care, Day Camp, etc.)
3. **Date expense was incurred** (i.e. Appointment Date, Visit Date, Date of Purchase)
4. **Total expense amount** (i.e. Patient Responsibility, Amount You Owe/Charged, Deductible/Co-Insurance/Copay Amount, Dollar Amount on Receipt for Item or Service, Total Due)
5. **Signature and date** (of claim submission)

You may use one line on the claim form to enter expenses which are identical in nature (i.e. office visit co-pays, RX co-pays, etc.) even if the expenses have been incurred on different dates. However, please make sure to attach documentation verifying each individual expense.

If your claim is denied, in part or in full, you can file an appeal. You can find the appeal procedure in your Summary Plan Description (SPD).

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.