



Tips for completing the receipt submission form

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.

Please ...

- Separate expense types by individual name.
- Complete the total requested amount.
- Include provider name, address and Tax ID (if Tax ID is 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 inch x 11 inch 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 records.

Please 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 eligible medical, dental, vision, and hearing expenses – complete part 2

Remember to check the MD, DN, VIS or HR box. Submit the form along with the explanation of benefits (EOB) statement that identifies the expense. Your insurance claim should be finalized before you submit for reimbursement. For expenses not covered by your insurance plan(s), including copayments, you must submit documentation that includes:

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)

For prescriptions (including prescribed OTC medicines) – complete part 2

Remember to check the RX box on the form. Most of the information we will require is usually found on prescription papers provided by pharmacies. You must submit documentation that includes:

Patient name * Out-of-pocket drug cost * Date the prescription was filled * Prescription name *OR*, NDC #
* *OR*, the word "copay" must be printed on the receipt

For eligible over-the-counter (OTC) medicines and supplies – complete part 2.

Remember to check the OTC box on the form. If claiming an OTC medicine, you must have a prescription (except for insulin) from your provider. OTC supplies do not require a prescription. You must submit documentation that includes:

Printed receipt * Name of the OTC item * Price * Date of purchase * OTC prescription (only if OTC drug or medicine)

For dependent care services – complete part 3

If all four fields in the Day Care Provider's Certification of Services Rendered section are completed, no further documentation is necessary. If all information is not completed, you must submit a statement that includes:

Provider's name * Provider's tax identification or social security number * Dates of service * Cost of service

Submitting your form and documentation

Please mail (or fax) the form and required documentation to the address (or fax number) provided at the top of the form. All reimbursement requests for a plan year must be postmarked prior to the filing deadline, which is specified in your benefit plan documents. Please refer to your benefit plan documents for health-related services that may not be covered under your specific 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 items and frequently asked questions are available at www.myuhc.com.
Mail form to:

Health Care Account Service Center
PO Box 981506
El Paso, TX 79998-1506
Fax (toll-free): 1-866-262-6354
Customer care (toll-free): 1-800-331-0480

UnitedHealthcare Debit Card Receipt Submission Form

Mail form to:

Health Care Account Service Center

PO Box 981506

El Paso, TX 79998-1506

Fax (toll-free): 1-866-262-6354

Customer care (toll-free): 1-800-331-0480

Part 1 Employee information Please print and 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		Employer Name	
<i>Please notify your benefits administrator of any address changes.</i>			

Part 2 Medical expenses Please print and 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												

¹Please 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 and 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:	
		/ /				
		/ /				
		/ /				
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#: <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> </tr> </table>											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:** _____