

## 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

**Complete Part 1** entirely and legibly. If you do not know your participant ID, Group Number or 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 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.
- Send original copies on white paper. Carbon copies and colored paper are not legible when scanned.
- Circle names and dollar amounts on receipts – especially important for OTC items.
- 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 or OTC.
- Do not submit pre-treatment estimates or estimated insurance statements.

For **Medical, Dental, Vision and Hearing Expenses**, submit your insurance carriers 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
- Date of service
- Dollar amount charged
- Patient's name
- Type of service
- Reason for non-coverage (Insurance Carrier's 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)

Non-prescription **Over-the-Counter (OTC) Drugs**, medicines, and medical care supplies check the OTC box on the claim form. Documentation must contain the following:

- Printed receipt
- Price
- Name of the over-the-counter item
- Date of purchase

**Dependent Care Services**, if all four fields in the Day Care Provider's Certification section are completed, no further documentation is necessary. In lieu of the Day Care Provider Certification section, submit a statement that includes:

- Provider's name
- Dates of service
- Tax identification or social security number
- 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 coverage information please refer to IRS publication 502, section 213 available at [www.irs.gov](http://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 online at [www.myuhc.com](http://www.myuhc.com).

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**Claim Submission / Withdrawal Request Form:**

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		Employer Name	

*Please notify your benefits administrator of any address changes.*

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 <sup>1</sup> (Please check)			Provider Tax ID # <sup>2</sup> (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 <sup>1</sup> (Please check)			Provider Tax ID # <sup>2</sup> (optional)												
MD	RX	OTC	VIS	DN	HR										

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

Dependent's Name	Date of Birth mm/dd/yyyy	Type of Service	Date(s) of Service mm/dd/yyyy		Request Amount
			From:	To:	
Dependent Care Expenses Subtotal					\$
<b>Total Request For Withdrawal</b>					<b>\$</b>

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#: <input type="checkbox"/> <input type="checkbox"/>	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: \_\_\_\_\_