UnitedHealthcare®

Medical/HRA Claim Submission / Withdrawal Request Form

MAIL CLAIM FORM TO:

UnitedHealthcare
PO Box 1747
Brookfield, WI 53008-1747
Fax: 1-800-760-3727
Customer Service 1-877-797-7475

Complete Part 1 entirely and legibly.

Complete Part 2 select the type of claim

Complete Part 3 if you are claiming medical, dental, vision, prescription or over-the-counter medication expenses. (Note: You must have a prescription for eligible over-the-counter drugs or medicines; medical supplies do not require a prescription, including insulin.)

All reimbursement requests for a plan year made during the following year must be received within plan submission guidelines. You may be asked to provide proof that you submitted your claim by the deadline.

DO

- Separate expense types by individual name.
- Complete the requested amount.
- Include provider name (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/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 prescription drug expenses.
- 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 copayments, 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 "copayment" 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), or **Eligible OTC Medical Care Supplies** (does not require a prescription – including insulin), you must check the OTC box on the claim form. Documentation must contain the following:

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

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** or by phone at **800-TAX-FORM**. A general list of eligible/non-eligible items along with frequently asked questions are available online at **myuhc.com.**

M49173 © 2011 United HealthCare Services, Inc.

Medical/HRA Claim Submission / Withdrawal Request Form

UnitedHealthcare

MAIL CLAIM FORM TO:

UnitedHealthcare
PO Box 1747
Brookfield, WI 53008-1747
Fax: 1-800-760-3727
Customer Service 1-877-797-7475

Part 1 Employee Information (Please Print) Itemize each expense using separate entries below. Use additional forms as necessary.

Employee name (Last and first)	Member ID (SSN or unique ID)	Daytime telephone no.
Mailing address, City, State, ZIP Code	Employer name	
Please notify your benefits administrator of any address changes	Employee email	

Part 2 Type of Claim[1] (Please check)

New claim ☐	Resubmission ☐	eClaim documentation ☐	Debit card documentation ☐

Part 3 Health Care Expenses (Please print) Itemize each expense using separate entries below. Use additional forms as necessary.

Type of Claim[1] (Please check)						Date of Service From:	Date of Service To:
MD ☐	RX ☐	OTC ☐	VIS ☐	DN ☐	HR ☐		
Patient name/Relationship						Provider name	
Description of service						Amount $	

Type of Claim[1] (Please check)						Date of Service From:	Date of Service To:
MD ☐	RX ☐	OTC ☐	VIS ☐	DN ☐	HR ☐		
Patient name/Relationship						Provider name	
Description of service						Amount $	

Type of Claim[1] (Please check)						Date of Service From:	Date of Service To:
MD ☐	RX ☐	OTC ☐	VIS ☐	DN ☐	HR ☐		
Patient name/Relationship						Provider name	
Description of service						Amount $	

Type of Claim[1] (Please check)						Date of Service From:	Date of Service To:
MD ☐	RX ☐	OTC ☐	VIS ☐	DN ☐	HR ☐		
Patient name/Relationship						Provider name	
Description of service						Amount $	

[1]Please check one box for each expense type: MD = Medical, RX = Prescription, OTC = Over-the-Counter, VIS = Vision, DN = Dental, HR = Hearing

EMPLOYEE SIGNATURE:____ DATE: ________________

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

M49173-B © 2011 United HealthCare Services, Inc.