Select one:

◯ Original submission

◯ Resubmission

A UnitedHealthcare Company

Flexible Spending Health Care Reimbursement Account Request

A. Instructions

- Attach an explanation of benefits (EOB) from the insurance carrier or an itemized receipt reflecting the patient responsibility
- If expense is covered by insurance, submit to appropriate carrier
- Rx print outs or receipts from a pharmacy provider
- Complete sections B, C, and D below
- Please include an itemized statement or bill from your provider indicating dates services were incurred. The following information should be included:
  (1) provider name and address
  (2) patient name
  (3) itemized charges
  (4) date(s) of service
  (5) type of service
- Cancelled checks, non-itemized receipts and balance due bills are NOT ACCEPTABLE proof of expenses
- You can file claims online at **umr.com**
- You can fax your completed claim form and supporting documentation toll free to **877-390-4782**
- You can also mail the completed form and supporting documentation to: **UMR / PO Box 8022 / Wausau WI 54402-8022**
- You can email the completed form and supporting documentation to **umr-fsa@umr.com**
- You can **electronically sign the form** by downloading it to your device. Once you download it and complete it, use the auto signature field to sign it electronically and save it to the device
- If you have questions, please call **800-826-9781** and say "consumer accounts" when prompted

B. Employee information

UMR Medical Identification Number _____ Employer _____

Plan year expense submitted for (YYYY) _____ Phone _____ Email address _____

Employee last name _____ Employee first name _____

Address _____ City _____ State _____ Zip code _____

C. Health care expenses

Date(s) of service from MM/DD/YY	Date(s) of service to MM/DD/YY	Provider (Doctor name/ Pharmacy name)	Type of service (copayment, OTC supplies, Rx, vision, orthodontia, dental)	Amount requested
___/___/___ MM DD YY	___/___/___ MM DD YY			$
___/___/___ MM DD YY	___/___/___ MM DD YY			$
___/___/___ MM DD YY	___/___/___ MM DD YY			$
___/___/___ MM DD YY	___/___/___ MM DD YY			$
___/___/___ MM DD YY	___/___/___ MM DD YY			$
			TOTAL REIMBURSEMENT REQUEST	$

If any of the amounts requested are to be used to offset an overpayment or substantiate a card transaction please check here. ◯
Please note claims will be used to offset any improper/unsubstantiated debit card transactions before any reimbursement can be made.

D. Certification

I certify that the expenses for which I am requesting reimbursement meet all the following conditions listed:
- The services were incurred by me or my eligible dependents under the plan
- They were for services or supplies furnished on or after the effective date of my IRS employee spending account
- I have not been reimbursed for these expenses in any other way

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my health care reimbursement account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

Employee signature *(required)* _____ Date ___/___/___ MM DD YY

(Continued)

Reimbursement instructions - please review

Eligible services and documentation requirements:

The expense must be a health-related expense incurred by you or one of your tax dependents. This means amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body. Expenses must be medically indicated and not for cosmetic purposes or general good health. A list of eligible and ineligible expenses can be found online at **umr.com**.

Supporting documentation must accompany this request form. Please adhere to the following guidelines:

DO

- Send an itemized bill showing the dates of service, type of service, provider name, patient's name and amount of service
- Send a copy of an explanation of benefits (EOB) from any insurance plan under which the expense is covered. When applicable, your insurance claim must be finalized prior to submitting for flex reimbursement
- Complete the total requested amount
- Send the documentation on white paper - carbon copies and colored paper are not legible when scanned
- Tape small receipts to a standard 8.5" x 11" sheet of blank paper, and ensure print is legible
- Include itemized receipts/documentation with the form
- Make a copy of the 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 submit balance forward statements
- Do not submit bank statements
- Do not highlight names, prices or dates on receipts - doing so makes them illegible when scanned
- Do not submit handwritten receipts for prescriptions or over-the-counter items
- Do not submit pre-treatment estimates or estimated insurance statements
- Do not submit date expense was paid, except for orthodontia payments

Actual dates of service must be indicated on the claim form. The IRS allows reimbursement for services when the care is provided, which may not be the actual date that the expense is paid or is formally billed for the charges

Explanation of benefits (EOB) email notification allows you to receive an email notifying you once your claim has been processed and an EOB is available to view online. Signing up is easy and convenient at **umr.com**

Web claim submission allows you to submit your claim online at **umr.com** and upload your supporting document

Letter of Medical Necessity (LOMN) is additional documentation needed when an item normally not considered eligible is needed to treat a specific medical condition. This letter would need to be completed by your provider stating which service or item is needed and for what type of condition. A LOMN is required annually. If you are not sure if a service or item will be covered, please review the listing of eligible/ineligible items available online, refer to your plan document or please contact UMR customer service.

Examples of items needing a LOMN are 1) vitamins/supplements 2) massage therapy 3) weight loss programs.

Limitations on reimbursement of over-the-counter supplies (stockpiling) will be followed. You will only be reimbursed for a reasonable quantity of an eligible over-the-counter medical care expense as determined by the plan administrator under the Plan (for example, 10 boxes of bandages purchased in one month would not be reasonable). **Please refer to your Plan Document to verify OTC items are eligible.**

Payments are issued once the total reimbursement amount reaches your plan's check minimum. Please contact UMR customer service to verify this amount.

Automatic reimbursement may be a feature your employer has chosen. This feature allows any patient liability amounts to be automatically reimbursed from your flexible spending account once your UMR medical, dental, and/or pharmacy claims are processed. If you have a non-UMR provider for these services, automatic reimbursement may still be available. Please contact UMR customer service to verify if this feature is allowed and if you are eligible to participate.

PLEASE NOTE: If you have automatic reimbursement for any of the benefits listed above, please do not submit a manual claim.

Health savings account (HSA) owners only: I understand that (1) I may not submit any expenses that would apply toward the deductible on my high-deductible health plan (HDHP) and (2) that I will be limited to reimbursement for dental and vision expenses only through my flexible spending account (FSA).

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