FLEXIBLE SPENDING ACCOUNT (FSA)

Claim Form

UnitedHealthcare

FSA Customer Service Center
P.O. Box 981506
EL PASO TX 79998-1506
Phone: 800-842-2026 • FAX: 915-231-1709
Toll Free FAX: 866-262-6354

FSA Grace Period

All FSA claims with dates of service from January 1 through March 15 will first be paid from your previous year's FSA balance (if funds are available) UNLESS you check the box in Part 2 or 3 labelled "Process claim only from current year funds."

Reminders

- Is your Employee Identification number (EIN) included on the form? (Your EIN is at the top of your biweekly earnings statement.)
- Is your total requested amount included on the form?
- Did you attach copies of your itemized documentation with your request? If needed, does your itemized bill show the date of service, a description of the service(s) provided, the patient name, and the fee charged? If covered by insurance, have you included an Explanation of Benefits (EOB) from you insurance plan? If not covered by insurance, have you noted this on your documentation?
- Did you sign and date the bottom of this form? If not, your request will be denied.
- Have you made copies of your request for your own personal records?

The following are examples of eligible supporting documentation that should be submitted with your request. A cancelled check is not adequate documentation.

Small receipts should be taped to a standard 8.5" x 11" sheet of paper and must be legible when scanned.

Part 2 - HEALTH CARE EXPENSES

Medical, Dental, Vision and Hearing Expenses

For expenses partially covered by your medical, dental or vision insurance plan, you must submit your Explanation of Benefits (EOB) statement with your completed claim form. If your EOB says that your dental or medical claim has been denied, and it does not describe the service or item in detail, also include an itemized statement from your dental or medical provider. This way, the FSA Customer Service Center knows the item or service was not denied by your insurance company because it was a cosmetic item or service (which cannot be paid through your FSA).

You may submit a Co-Pay receipt if this is your only expense.
For expenses not covered by your medical, dental or vision insurance plan, you must submit the following information:

- Name and Address of the provider
- Dates of Service
- Dollar amount charged
- Patient's Name
- Type of Service
- Write "Not Covered by Insurance" on the receipt

PRIVACY ACT: Completing this form, which is used to process claims from your FSA account, is voluntary; however, without the information, we will be unable to process your request. Your copy of the *PostalEASE* FSA Worksheet includes a Privacy Act statement that lists the routine uses for which this information may be disclosed. If you are unable to locate your copy, you may obtain one from the Human Resources Shared Service Center (HRSSC). Authority: 39 U.S.C. 401, 1001, 1003, 1005; 5 U.S.C. 8339.

Over-the-Counter (OTC) Drugs and Medicines

When submitting a receipt for an over-the-counter drug or medicine, you must include a prescription from your health care provider, and a receipt that shows name of the over-the-counter drug or medicine, the price, and the date of purchase. Handwritten over-the counter item names on register receipts are unacceptable. The name of the item(s) and price(s) must be circled on the receipt. Receipts should be taped to a standard 8.5" x 11" inch piece of paper and must be legible when scanned. You do not need a prescription to be reimbursed for insulin.

Over-the-Counter (OTC) Supplies

When submitting a receipt for an over-the-counter supplies such as bandages, contact lens supplies and solutions, first aid supplies, and reading glasses, or for insulin, circle RX/OTC on the claim form. A printed receipt must include the name of the over-the-counter item, the price and the date of purchase. Handwritten over-the-counter items names on register receipts are unacceptable. The name of the item(s) and price(s) must be circled on the receipt. Receipts should be taped to a standard 8.5" x 11" sheet of blank paper. Receipts must be legible when scanned.

Part 3 - DEPENDENT CARE EXPENSES

Dependent Care Services

(1) You must complete the blocks under "Dependent Care Expenses." (2) You must attach a receipt that shows the date(s), type and cost of the service. (3) Your provider must complete the "Dependent Care Provider's Certification of Services Rendered" or all of the requested information, including the signature, must be included on the receipt that you attach.

FLEXIBLE SPENDING ACCOUNT Claim Form

UNITED STATES POSTAL SERVICE®

Please Read These Instructions Before Completing the FSA Claim Form

1. Employee must complete Part 1. Read the instructions for completing Parts 2 and 3 on the reverse of this form.
2. Read the Certification For Reimbursement, sign and date the form. Make a copy of this form and any documents you send for your records.
3. All reimbursement requests for a plan year made during the following year must be postmarked prior to the filing deadline, which is specified in your plan documents.
4. Mail (or FAX) the form to **UnitedHealthcare, FSA Customer Service Center,** P.O. Box 981506, El Paso TX, 79998-1506 • Phone: 800-842-2026 • 711 Relay via TRS • FAX: 915-231-1709
Toll Free FAX: 866-262-6354

PART 1 EMPLOYEE INFORMATION *(Please Print)*

EMPLOYEE NAME *(Last and First)*	EMPLOYEE IDENTIFICATION NUMBER	DATE OF BIRTH / /	DAYTIME TELEPHONE NO. – –
EMPLOYEE ADDRESS		FSA GROUP NUMBER **141245**	EMPLOYER NAME **USPS**

PART 2 HEALTH CARE EXPENSES *(Please Print)* Please place each expense on a separate line

PATIENT'S NAME	DATE(S) OF SERVICE MM/DD/YYYY Date Started	Date Ended	TYPE OF SERVICES Circle for each expense • MD=medical RX/OTC=prescription/OTC • VS=vision • DN=dental • HR=hearing	REQUEST AMOUNT
	/ /	/ /	MD RX/OTC VS DN HR	
	/ /	/ /	MD RX/OTC VS DN HR	
	/ /	/ /	MD RX/OTC VS DN HR	
	/ /	/ /	MD RX/OTC VS DN HR	
	/ /	/ /	MD RX/OTC VS DN HR	
All claims dated January 1 through March 15 will first be paid from your previous year's FSA balance (if funds are available) UNLESS you check the box below: ☐ Process claim only from current year funds			**HEALTH CARE EXPENSES SUBTOTAL**	**$**

PART 3 DEPENDENT CARE EXPENSES *(Please Print)* Please place each expense on a separate line

DEPENDENT'S NAME	DATE OF BIRTH	DATE(S) OF SERVICES Date Started	Date Ended	TYPE(S) OF SERVICES	REQUEST AMOUNT
		/ /	/ /		
		/ /	/ /		
All claims dated January 1 through March 15 will first be paid from your previous year's FSA balance (if funds are available) UNLESS you check the box below: ☐ Process claim only from current year funds			**DEPENDENT CARE EXPENSES SUBTOTAL**		**$**
			TOTAL REQUEST FOR WITHDRAWAL		**$**

Dependent 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.

Dependent Care Provider's Company Name and Signee Name:	Dependent Care Provider's Address:
Dependent Care Provider's Tax ID# or SSN:	Dependent Care Provider's Signature:

CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for which I am requesting reimbursement from my Health Care FSA or Limited 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 or Limited FSA and have not been and will not be reimbursed by any other plan.

I certify that the expenses for which I am requesting reimbursement from my Dependent Care FSA, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) for dependent care as permitted under the Dependent Care FSA and have not been and will not be reimbursed by any other plan.

I understand that expenses reimbursed through the FSA program cannot be used to claim any Federal Income Tax deduction and/or credit. To the best of my knowledge and belief, my statements on this form are complete and true.

EMPLOYEE SIGNATURE: **DATE:**

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.