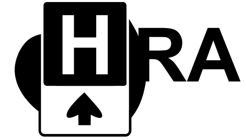
Health Reimbursement Account Claim Form



Part A:
PERSONAL INFORMATION

Last Name | First Name | Phone Number

Member ID Number | Name of Employer

Part B:
REIMBURSEMENT INFORMATION

Service Date from | Service Date to | Reimbursement Requested $.

Provider Name | Type of Service*

Service Date from | Service Date to | Reimbursement Requested $.

Provider Name | Type of Service*

Service Date from | Service Date to | Reimbursement Requested $.

Provider Name | Type of Service*

Total Reimbursement .

Part C:
Attach **COPY** of itemized receipts.

* Be specific with the type of service

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- They were incurred for services or supplies received by my eligible dependents or me under the plan.
- They were for services or supplies furnished on or after the effective date of my employee reimbursement account.
- I have not been reimbursed for these expenses in any other way or from any other source.
- They are for eligible expenses based on IRS section 213d and allowed per my employer's plan. (Please refer to your Plan document to verify what expenses are allowed)

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 nor will I deduct on my individual 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 sole responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability. UMR shall not be liable for any penalties or damages as a result of an inappropriate claim filed by me. I will retain a copy of this form and all original receipts for my records.

Employee Signature | **Date**

FAX TO: 877-390-4782
SEND TO: UMR PO Box 8022, Wausau WI 54402-8022
EMAIL TO: umr-fsa@umr.com
INQUIRIES: 800-826-9781 or email

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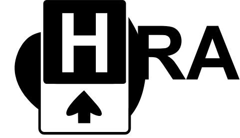

Reimbursement Instructions – Please Review

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 listing of eligible and ineligible expenses can be found online at www.umr.com.

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

DO	DO NOT
➢ 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 and documentation with the form ➢ Make a copy of the form and documentation for your personal records	➢ 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 patient pays or is formally billed for the charges.

EOB E-mail Notification allows you to receive an e-mail notifying you once your claim has been processed and an EOB is available to view online. Signing up is easy and convenient at www.umr.com.

Web Claim Submission allows you to submit your claim online at www.umr.com. Please print the cover sheet and fax it along with your documentation to 866-881-1200.

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. Generally, LOMNs are needed for the following types of expenses. A LOMN is required annually.

- Vitamins or supplements
- Health club memberships
- Massage therapy
- Weight loss programs, including some food items

If you are not sure if a service or item will be covered, please contact UMR customer service.

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 (i.e., 10 boxes of band aids 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.