ORIGINAL SUBMISSION
RESUBMISSION

Flexible Spending Health Care Reimbursement Account Request



A. INSTRUCTIONS

- Complete sections B, C, and D
- Attach an explanation of benefits (EOB) from the insurance carrier or an itemized receipt reflecting the patient responsibility
- Rx print outs or receipts from pharmacy provider
- > Itemized bills should include the following:
- Provider name and address 2) Patient name 3) Itemized charges 4) Date 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: www.umr.com
- You can fax completed claim form and supporting documentation toll free to 877-390-4782

You can en	nail the completed	form an	and supporting documents and supporting documents	tation	to: umr-fsa@ui	nr.com	au WI 54402-8022	
➤ If you have	e questions, please	call: 80	00-826-9781 and say of B. EMPLOYEE			when prompted		
UMR MEMBER IDENTIFICATION NUMBER					EMPLOYER			
PLAN YEAR EXPENSE SUBMITTED FOR (YYYY)					E-MAIL ADDRESS			
EMPLOYEE LAST NAME				EMPLOYEE FIRST NAME				
ADDRESS	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 NAM		≣)	SUPPLIES	VICE (COPAY, OTC S, RX, VISION, NTIA, DENTAL)	AMOUNT REQUESTED	
							\$	
							\$	
							\$	
							\$	
							\$	
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 below: > They were incurred for services or supplies by me or my eligible dependents under the plan > They were for services or supplies furnished on or after the effective date of my healthcare 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 healthcare spending 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)				DAT	E			

Reimbursement Instructions

Eligible Services and Documentation Requirements:

DO

The expense must be a healthcare-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.

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

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>	Send an itemized bill showing the dates of service, type of service,	Do not submit cancelled checks or credit card receipts alone,
	provider name, patient's name and amount of service	these are not adequate documentation without supporting
>	Send a copy of an explanation of benefits (EOB) from any	itemization
	insurance plan under which the expense is covered, when	Do not submit balance forward statements
	applicable your insurance claim must be finalized prior to	Do not submit bank statements
	submitting for flex reimbursement	Do not highlight names, prices or dates on receipts, doing so
>	Complete the total requested amount	makes them illegible when scanned
>	Send the documentation on white paper, carbon copies and colored paper are not legible when scanned	 Do not submit handwritten receipts for prescriptions or over-the- counter items
>	Tape small receipts to a standard 8.5" x 11" sheet of blank paper and ensure print is legible	 Do not submit pre-treatment estimates or estimated insurance statements
>	Include itemized receipts and documentation with the form	Do not submit date expense was paid, except for orthodontia
>	Make a copy of the form and documentation for your personal records	payments

DO NOT

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, and upload your supporting documentation.

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 band aids 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).