☐ **ORIGINAL SUBMISSION**
☐ **RESUBMISSION**

Health Care Reimbursement Account Request

A. INSTRUCTIONS

- Complete sections B, C, and D
- If expense is covered by insurance, submit to appropriate carrier
- Attach explanation of benefits (EOB) from the insurance carrier or co-pay receipts
- Itemized bills should include the following:
  1) 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
- If you have questions, please call: **800-826-9781, or contact us online at www.umr.com**
- Mail completed form along with appropriate documentation to:
  UMR
  Attention: Flexible Spending Department
  PO Box 8022, Wausau, WI 54402-8022
- You can also fax claims toll-free to: **877-390-4782**

B. EMPLOYEE INFORMATION

EMPLOYEE MEMBER IDENTIFICATION NUMBER		EMPLOYER	
PLAN YEAR EXPENSE SUBMITTED FOR (YYYY)	PHONE	E-MAIL 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 (I.E. DOCTOR NAME/PHARMACY NAME	TYPE OF SERVICE (I.E., CO-PAYMENT, OTC, RX, VISION, ORTHODONTIA, 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: even if not checked claims will be used to offset any improper/unsubstantiated card transactions before any reimbursement can be made)***

D. CERTIFICATION

I certify that the expenses for which I am requesting reimbursement meet all of 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 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 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)	DATE

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 DOs and DO NOTs:

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. 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 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. They are not legible 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.

Fax Verification is available by calling 800-826-9781 and following the appropriate prompts. The Interactive Voice Response (IVR) system can verify faxes received within the last 30 days.

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 Drugs/Items (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 bottles of aspirin in one month would not be reasonable).

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).