

MAIL CLAIM FORM TO:

United Healthcare
PO Box 981178
El Paso, TX 79998-1178
Fax: (915) 781-1085; Customer Service Phone: (800) 510-4846
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FSA CLAIM FILING INSTRUCTIONS – GROUP #709593

- 1) Complete Part 1 entirely and legibly. Please refer to your ID card for Participant ID number.
- 2) Completed Part 2 if you are claiming health care expenses (Medical, Rx, or over-the-counter drugs, hearing, dental or vision).
- 3) Complete Part 3 if you are claiming Dependent Care expenses. Carefully, read and follow the directions below regarding the Provider’s Certification of Services Rendered.

DO

DO NOT

- Separate expense types by individual name.
- Complete the total requested amount.
- Send original copies on white paper. Carbon copies and colored paper are not legible when scanned.
- Circle names and dollar amounts on receipts – especially important for OTC items.
- Tape small receipts to a standard 8.5” x 11” sheet of blank paper. Ensure print is legible.
- Attach itemized receipts/documentation to the form.
- Read Certification for Reimbursement, sign and date form.
- Make a copy of form and documentation for your personal records.
- Please wait to submit expenses until you have accumulated a minimum of \$50.00.

- Do not submit cancelled checks or credit card receipts alone. These are *not* adequate documentation without supporting itemization.
- Do not highlight names, prices or dates on receipts. They are not legible when scanned.
- Do not handwrite item names on receipts. These are not acceptable.
- Do not submit handwritten receipts for Rx or OTC.
- Do not submit pre-treatment estimates or estimated insurance statements.

For **Medical, Dental, Vision and Hearing Expenses**, submit your insurance carriers Explanation of Benefits (EOB) statement with your completed form. When applicable your insurance claim must be finalized prior to submitting for reimbursement. For expenses not covered by your medical, dental or vision insurance plan and for co-payments you must submit documentation which includes the following information:

* Name and Address of Provider * Dollar amount charged * Date of service * Patient’s name * Type of Service
*Reason for non-coverage (Insurance Carrier EOB if applicable)

Prescription documentation must contain the following:

*Patient name *Out of pocket cost of the drug *Date the prescription was filled *Prescription name **or** NDC # **or** the word copy must be printed on the receipt*(Information usually can be found on prescription tags provided by pharmacies)

Non-prescription **Over-the-Counter (OTC) Drugs**, medicines, and medical care supplies, check the OTC box on the claim form. Documentation must contain the following:

*Printed receipt *Name of the over-the-counter item *Price *Date of purchase

Dependent Care Services, if all four fields in the Day Care Provider’s Certification section are completed, no further documentation is necessary. In lieu of the above submit a statement that includes:

*Provider’s name *Provider’s Tax identification or social security number *Dates of service *Cost of service

Refer to the provisions in your Summary Plan Document (SPD) for the minimum and maximum annual election amounts. IRS Sections 125 regulations indicate that an expense is considered incurred at the time of service giving rise to the expense is provided, and not when you are formally billed for, charged for, or pay for an expense. The expense must be incurred during the period you and your dependents are covered under the plan. All eligible expenses for active employees for current plan year (July-June) must be received within **90 days** after the end of the plan year (July - June), **September 30th**. Terminated employees must file by the deadline in the SPD (**90 days after last day of coverage**).

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REIMBURSEMENT ACCOUNT WITHDRAWAL REQUEST (CLAIM FORM)

Part 1 Participant Information (Please Print) Please read the instructions on Page 1 before completing form.

Participant Name (Last and First)	Participant ID	Date of Birth	Daytime Telephone No
Mailing Address Please notify your benefit administrator of any address changes.		FSA Group # 709593	Employer Name Foothill-De Anza Community College District

Part 2 Health Care Expenses (Please Print) itemize **each expense type** using a separate line. Use additional forms as necessary.

Patient's Name	Type of Services	Date(s) Of Service		Request Amount
	Please Check One Box Below For Each Expense Type MD=Medical Rx=Prescription OTC= Over-The-Counter VS=Vision DN=Dental HR=Hearing	mm/dd/yyyy		
	MD <input type="checkbox"/> Rx <input type="checkbox"/> OTC <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/>	From:	To:	
	MD <input type="checkbox"/> Rx <input type="checkbox"/> OTC <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/>	From:	To:	
	MD <input type="checkbox"/> Rx <input type="checkbox"/> OTC <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/>	From:	To:	
	MD <input type="checkbox"/> Rx <input type="checkbox"/> OTC <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/>	From:	To:	
	MD <input type="checkbox"/> Rx <input type="checkbox"/> OTC <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR <input type="checkbox"/>	From:	To:	
Health Care Expenses Subtotal				\$

Part 3 Dependent Care Expenses (Please Print) itemize **each** expense using a separate line. Use additional forms as necessary.

Dependent's Name	Date Of Birth mm/dd/yyyy	Type Of Service	Date(s) Of Service		Request Amount
		i.e. Daycare, Day Camp, After School Care	mm/dd/yyyy		
			From:	To:	
			From:	To:	
			From:	To:	
			From:	To:	
Dependent Care Expenses Subtotal					\$
Total Request For Withdrawal					\$

Day 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 have been paid for.

Day Care Provider and Company Name:	Day Care Provider's Address:
Day Care Provider's Tax Id#: □ □ □ □ □ □ □ □ □ □	Day Care Provider's Signature and Title:

Certification For Reimbursement

I certify that any expenses for which I am requesting reimbursement from my Health Care/Dependent Care 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/Dependent Care FSA, and have not been reimbursed and I will not seek reimbursement under any other plan. I understand that expenses reimbursed through the FSA program cannot be used to claim any federal income tax deduction or credit. To the best of my knowledge and belief, my statements are complete and true.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

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**REIMBURSEMENT ACCOUNT INELIGIBLE AND ELIGIBLE EXPENSE EXAMPLES
GROUP #709593**

Examples of Eligible Health Care Expenses:

- Acupuncture	- Diabetic supplies	- Prescription drugs
- Childbirth expenses	- Guide dogs	- Psychological treatment
- Chiropractic services	- Hearing aids/batteries	- Speech therapy
- Coinsurance/co pays	- Laboratory fees	- Surgical fees
- Contact lenses and solutions	- Laser eye surgery	- Transportation fees necessary for medical treatment
- Deductibles	- Orthodontia	- Vaccinations
- Dental expenses	- Over-the-counter drugs*	- Vision expenses
- Dentures	- Pediatric services	

* Select "RX" on the claim form for over the counter drugs. A doctor's note may be required for certain over-the-counter drugs.

Examples of Non-Reimbursable Health Care Expenses :

- Fee for exercise, athletic, or health club membership	- Funeral expenses
- Weight reduction programs for general well-being	- Liposuction
- Stop smoking program for general well-being	- Marriage counseling
- Any illegal treatment	- Teeth bleaching
- Insurance premium	- Union dues
- Dancing/ballet/swimming lessons, even when recommended by physician	- OTC drugs, products, or formulas for general health (herbal remedies, vitamins, beauty aids, lotion, toothpaste)
- Diaper Services	

Dependent Care Eligible Expenses Listing:

An Eligible dependent is any dependent who is less than 13 years old and your dependent under federal income rules. An eligible dependent may also include your mentally or physically impaired spouse or a dependent who is incapable of caring for him or herself (for example, an invalid parent). The dependent must spend at least eight hours per day in your home.

Child care services will qualify for reimbursement from the Dependent Care Reimbursement Account if they meet requirements:

- * The child must be under 13 years old and must be your dependent under federal tax rules. Note: if your child turns 13 during the year, you cannot stop your contribution at that time.
- * The services may be provided inside or outside your home, but not by someone who is your minor child or dependent for income tax purposes (for example, an older child).
- * If the services are provided by a day-care facility that cares for six or more children at the same time, it must be qualified day care center.
- * The services must be incurred to enable you, or your and your spouse (if married), to be employed.
- * The amount to be reimbursed must not be greater than your spouse's income or one-half your income, whichever is lower.
- * Services must be for the physical care of the child, not for education, meals, etc.

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Allowable Dependent Care Reimbursement Account Expenses:

<ul style="list-style-type: none"> - Child care centers - Babysitters - Nursery school - Caregivers for a disabled dependent for spouse who lives with you. 	<ul style="list-style-type: none"> - Household services, provide that a portion of these expenses are for a qualifying dependent incurred to ensure the dependent's well-being maintenance. - Family day care centers - Adult day care facilities - After school programs
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Examples of Non-Reimbursable Dependent Care Expenses:

<ul style="list-style-type: none"> - Sleep away overnight camps - 24-hour nursing home care - Tuition fees for private or boarding schools - Health care expenses for your dependents - Expenses for which you claim a tax credit on your federal income tax return 	<ul style="list-style-type: none"> - Transportation expenses - Weekend or evening baby-sitting that is not necessary for you (and your spouse) to work - Care provided for your child by a sibling under the age of 19 or someone you claim as a dependent on your income tax return
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The examples provided on this claim form document are only some examples for eligible/ineligible expenses that can currently be reimbursed through the Reimbursement Accounts. If you have any expenses that are in question, please feel free to contact a UnitedHealthcare representative at (800) 510-4846.

For a detailed list of eligible expenses, please refer to IRS Publication 502 (Health Care Expenses) and 503 (Child and Dependent Care Expenses), available online at www.irs.gov.

A general list of eligible/non-eligible items along with frequently asked questions, and claim status, please access online at: www.myuhc.com

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Notice Requirements:

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.