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

Flexible Spending
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
- Rx print outs or receipts from pharmacy provider
- 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
- **You can file claims online** or fax completed claim form & supporting documentation toll free to 877-390-4782
- You can also mail the completed form & supporting documentation to: **UMR / PO Box 8022 / Wausau WI 54402-8022**
- If you have questions, please call: **800-826-9781, or contact us online at www.umr.com**

B. EMPLOYEE INFORMATION

UMR 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 SUPPLIES, 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 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 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, 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/supplement 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 (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.

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).