OPTUM®

FSA/HRA Claim for Reimbursement

TIME SAVING TIP: Did you know you can file your claim online at **www.optumhealthfinancial.com** *instead of completing this form? Simply log in to your account and click "File A Claim" under the "I Want To," section on the home page.*

Customer service professionals can be reached by calling 1-800-243-5543 (Monday - Friday from 8 a.m. to 10 p.m. and Saturday - Sunday from 9 a.m. to 5:30 p.m. Eastern time) if you have any questions.

1012 HA FSA HRA

1 About you

First Name, Last Name	Last 4 of SSN:	Employer/Plan Sponsor Name:
Participant Address:	City, State ZIP:	

2 About your expenses

Use one line in this section for each expense type. If you have multiple expenses of the same type, for example copays, you may request payment on one line for the entire date range. If you have more eligible expenses than space allows in this section, please submit as many FSA/HRA Claim for Reimbursement Forms as needed.

Healthcare Expenses	Date of service MM/DD/YY *Example: 1/1/15 thru 1/31/15*	Expense Amount Claimed *Example: $125.00*	Name of Person Receiving product or service *Example: John Doe*	Name of Service Provider *Example: ABC Insurance Co.*	Type of Expense (Medical, Vision, Premium, etc.) *Example: Insurance Premium*
EXPENSE ❶		$			
EXPENSE ❷		$			
EXPENSE ❸		$			
EXPENSE ❹		$			
EXPENSE ❺		$			

Dependent Care Expenses	Date of service MM/DD/YY	Expense Amount	Name of Service Provider	Dependent Receiving Service		Provider Certification *(in place of supporting documentation)*		
				Age	Name	Amount	Signature	Tax ID #
DEPENDENT ❶		$				$		
DEPENDENT ❷		$				$		
DEPENDENT ❸		$				$		

3 Agreement and Signature

By submitting this form, I certify that: all expenses I am submitting for reimbursement were incurred: by me or another individual eligible under my company's FSA or HRA plan. All expenses I am submitting for reimbursement were incurred during a period I was covered by the company's FSA or HRA plan. None of the expenses I am submitting for reimbursement have been reimbursed by or, if applicable to my plan, are reimbursable from any other source. I am fully responsible for the sufficiency and accuracy of information relating to the reimbursement submission, and that if an expense for which reimbursement is claimed is subsequently determined to not be an eligible expense under my plan, I may be liable for repayment to the plan and payment of all related taxes, including federal, state, or local income tax, on amounts paid from the plan. I acknowledge and agree that I have had an opportunity to consult with my tax advisor prior to submitting this form. If I participate in a group health plan that does not provide Minimum Value, as defined by the IRS, I certify that expenses I submit for reimbursement under my health reimbursement arrangement (HRA) are limited to copayments, coinsurance, deductibles, premiums under the non-HRA group coverage and medical care that does not constitute essential health benefits, as defined by the Affordable Care Act (ACA) and applicable state law. Consult your plan sponsor to determine if your plan provides Minimum Value.

✗ _____ _____

Participant's Signature Date

STOP Don't forget to attach **legible supporting documentation** before mailing your form to the address below. Your documentation must clearly identify. Remember that the dependent care provider may complete the Provider Certification in Step 2 in place of itemized documentation.

1. Total expense amount
2. Description of expense
3. Date expense was incurred
4. Name of person receiving service
5. Name of person/entity providing service
6. Signature and date of claim submission

Thank you for allowing us to serve you.

Where to return your form and documentation?
By Mail: Optum, P.O. Box 30516, Salt Lake City, UT 84130
By Email: optumclaims@prod.sourcehov.com
By Fax: 1-855-244-5016