**Select One:**
☐ **ORIGINAL SUBMISSION**
☐ **RESUBMISSION**

A UnitedHealthcare Company

# Health Reimbursement Account (HRA)
# Claim form

## How to complete the form

- Complete sections A, B and C.
- Attach an Explanation of Benefits (EOB) from the insurance carrier, prescription drug co-pay receipts, or a printout of drugs purchased from your pharmacy provider. The document(s) attached needs to include all of the following:
  1) Provider name and address 2) Patient name 3) Itemized charges 4) Date of service 5) Type of service
- Canceled 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.**

## A. Employee information

| UMR Employee Identification Number (from front of ID card) | Employer | | |
|---|---|---|---|
| Employee Name (Last, First) | | Phone Number or E-mail Address | |
| Address | City | State | Zip Code |
| Patient Name (Last, First) | | Patient Date of Birth | |

## B. Expenses

| Start Date of Service MM/DD/YY | End Date of Service MM/DD/YY | Provider of Service (doctor or pharmacy) Include name and address | Type of Service | Amount of Reimbursement Requested |
|---|---|---|---|---|
| | | | ☐ Prescription ☐ Other _____ | $ |
| | | | ☐ Prescription ☐ Other _____ | $ |
| | | | ☐ Prescription ☐ Other _____ | $ |
| | | | ☐ Prescription ☐ Other _____ | $ |
| | | | ☐ Prescription ☐ Other _____ | $ |
| | | | **TOTAL REIMBURSEMENT REQUEST:** | $ |

## C. 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 health reimbursement 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 reimbursement 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 **(Required)** |
|---|---|
| | |

**Mail:** UMR
PO Box 30541
Salt Lake City, UT 84130-0541

**For Inquires:** www.umr.com or call 800-826-9781

**Email a pdf of your claim and documents to:** dohtclaims@umr.com

**Fax:** 855-405-2189

**SUBMIT**

# Reimbursement Instructions – Please Review

## Eligible Services and Documentation Requirements:

The expense must be a health-related expense incurred by you or one of your eligible 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 necessary and not for cosmetic purposes or general good health.

**Supporting Documentation** must accompany this request form. Please adhere to the following DOs and DO NOTs:

| DO | DO NOT |
|---|---|
| ➢ Send an itemized bill or receipts showing the dates of service, type of service, provider name, patient's name and amount of service with this form.<br>➢ 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 HRA reimbursement.<br>➢ Complete the total requested amount.<br>➢ Send the documentation on white paper. Carbon copies and colored paper are not legible when scanned.<br>➢ Tape small receipts to a standard 8.5" x 11" sheet of blank paper. Ensure print is legible.<br>➢ Make a copy of the form and documentation for your personal records. | ➢ Do not submit canceled checks or credit card receipts alone. These are not adequate documentation without supporting itemization.<br>➢ Do not submit balance forward statements.<br>➢ Do not submit bank statements.<br>➢ Do not highlight names, prices, or dates on receipts. They are not legible when scanned.<br>➢ Do not submit handwritten receipts for prescriptions or over-the-counter items.<br>➢ Do not submit pre-treatment estimates or estimated insurance statements.<br>➢ Do not submit date expense was paid. |

**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.

**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 if your plan allows reimbursement of over-the-counter supplies. 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.**

**Automatic Reimbursement** may be a feature your employer has chosen. This feature allows any patient liability amounts to be automatically reimbursed from your health reimbursement account once your UMR medical claims are processed when you have a UMR medical plan. 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 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).