



CLAIM FOR REIMBURSEMENT

First Name:

Last Name:

SSN:

Employer Name: _____

Email Address: _____

Email Change

Participant Address: _____

Address Change

ELIGIBLE HEALTH CARE EXPENSE CLAIMS

| Line | Date Expense Incurred (Month/Day/Year) | Expense Amount Claimed | Detailed Description of Expense | Person to Whom Expense Incurred (self, spouse, etc.) | Name of Service Provider |
|------------------------------|---|------------------------|---------------------------------|---|--------------------------|
| 1 | to | \$ | | | |
| 2 | to | \$ | | | |
| 3 | to | \$ | | | |
| 4 | to | \$ | | | |
| 5 | to | \$ | | | |
| Total Medical Expense Claim: | | \$ | | | |

ELIGIBLE DEPENDENT CARE EXPENSE CLAIMS

| Line | Date Expense Incurred (Month/Day/Year) | Expense Amount Claimed | Name of Daycare Provider | Dependents Who Received Service Age Name | Provider Certification | | Tax ID# or Provider |
|------------------------------|---|------------------------|--------------------------|---|------------------------|-----------|---------------------|
| | | | | | Amount | Signature | |
| 1 | to | \$ | | | \$ | | |
| 2 | to | \$ | | | \$ | | |
| 3 | to | \$ | | | \$ | | |
| 4 | to | \$ | | | \$ | | |
| 5 | to | \$ | | | \$ | | |
| Total Daycare Expense Claim: | | \$ | | | \$ | | |

By signing and submitting this form, I certify:

That all expenses I am submitting for reimbursement were incurred by me, or by someone who qualifies as my spouse or dependent for the purpose of federal income taxes and were incurred during a period I was covered by the company's plan. That the expenses have not been reimbursed, or are not reimbursable, from any other source.

That I alone am fully responsible for the sufficiency and accuracy of all information relating to the claim submission, and that if an expense for which payment or reimbursement is claimed is subsequently determined to not be a proper expense under the Plan, I may be liable for repayment to the plan or payment of all related taxes, including federal, state, or local income tax, on amounts paid from the Plan.

Note: If you are enrolled in and contributing to a Health Savings Account (HSA), reimbursements from other health expense reimbursement accounts (FSAs or HRAs) are limited to dental or vision expenses, expenses related to preventative care (if offered by your plan), and expenses that exceed the health plan deductible (if offered by your plan).

Participant's Signature

Date

Attach a copy of bill, invoice or written statement, including the date of service, from a third-party supporting the request. NOTE: Provider Certification may be furnished in place of a copy of a bill. Attach a copy of any explanation of benefit statement that shows the deductible, co-insurance or amounts not covered by medical/dental plan.

MAIL OR FAX CLAIM TO: OptumHealth, Attention: EV Team, P.O. Box 30516, Salt Lake City, UT 84130-0516 | Fax: 1-855-244-5016 | Phone: 1-800-243-5543 | OptumHealthFinancial.com

SUBMITTING CLAIMS

There are four methods of submission available for your claim form and documentation:

Online - Please visit our website at OptumHealthFinancial.com and follow the claim submission link through your login. Further instructions for claim submission are provided at the web location.

E-mail - Claims may be e-mailed (with scanned in documentation attached) to slc_optumev1@hovservicesprod.com. E-mailed claims received by OptumHealth Financial Services after 1:00 PM Central time will be considered as received on the following business day.

Fax - Claims may be faxed to OptumHealth Financial Services with documentation to 1-855-244-5016. Faxed claims received by OptumHealth Financial Services after 1:00 PM Central time will be considered as received on the following business day.

Mail - Claims should be sent to: OptumHealth, Attention: EV Team, P.O. Box 30516, Salt Lake City, UT 84130-0516.

Regardless of your submission method, you will want to make sure you submit legible documentation. If we are unable to read items because of the quality of the copy or the fax, the claim will be denied pending resubmission of legible documentation. Supporting documentation must clearly identify:

- 1. Name of person/entity providing service**
- 2. Nature of expense**
- 3. Date expense was incurred**
- 4. Total expense amount**
- 5. Signature and date (of claim submission)**

You may use one line on the claim form to enter expenses which are identical in nature (i.e. office visit co-pays, RX co-pays, etc.) even if the expenses have been incurred on different dates. However, please make sure to attach documentation verifying each individual expense.

If your claim is denied, in part or in full, you can file an appeal. You can find the appeal procedure in your Summary Plan Description (SPD).

MEDICAL EXPENSE CLAIMS

To be eligible for reimbursement under the plan, you must provide proof the expenses were incurred. Please attach a copy of an itemized statement from the provider. Expenses are only eligible if they are incurred while you are participating in the plan. Expenses may be incurred by you, your spouse or other individuals who qualify as eligible dependents under federal rules. Note: Reimbursements from the health care reimbursement account may be limited to dental or vision expenses if you are covered under a Health Savings Account (HSA).

Examples of eligible expenses that your plan may allow include co-payments, deductibles, unreimbursed medical, dental, and vision expenses, therapy you receive as medical treatment, prescription drugs, Over-the-counter (OTC) drugs or medicines, other than insulin, require a prescription to be reimbursable (e.g. aspirin, antacids, pain relievers, cold medication, allergy medicine). Eligible OTC medical supplies and equipment do not require a prescription (e.g. contact solution, bandages, crutches, blood sugar test kits).

DEPENDENT DAY CARE CLAIMS

Eligible dependents include your children under age 13, or if older, the person receiving care must be physically or mentally incapable of self care. See your SPD for additional information on Qualifying Individuals and certain benefit maximums which apply. Reimbursement for dependent care expenses are eligible if these amounts are paid to permit you to work. If you are married, dependent care expenses are only eligible if your spouse is also working for pay, attending school, or seeking employment while you are at work.

To request reimbursement, complete the dependent care section of the claim form and attach proof the dependent care services were provided by attaching an itemized statement or by having your dependent care provider complete the Provider Certification portion of the form. According to federal law, you must report the name, address and taxpayer identification number of the dependent care provider when you file your tax return.

To access your account information, log on to OptumHealthFinancial.com.