Request for Reimbursement

for Dependent Care Expenses

What is this form for?

Use this *Request for Reimbursement* form to ask for payment from your Dependent Care FSA for eligible care you've already paid for with a credit card, cash or check.

Note: Requests may be submitted only up to 35 days in advance of services received.



Get your money back faster. Submit your expenses online.

You can skip this form and easily submit your expenses online for faster reimbursement. Plus, it reduces errors and saves paper. Here's how:

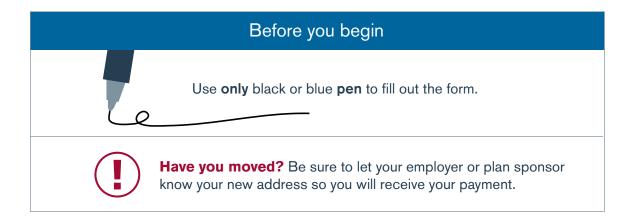
- 1. Log in to your member website.
- 2. Follow the steps to submit a claim form.

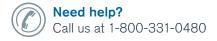
Why submit online?

- ▶ Your form is instantly submitted for review.
- ▶ You may be able to sign up for email/text alerts to track payments.

What expenses are eligible?

- ▶ A general list of eligible expenses and frequently asked questions is available on your member website.
- ▶ **Don't miss the deadline:** Your request **must** be postmarked **before** the submission deadline, which you can find in your benefits document. For help, contact your employer or plan sponsor.







Part 1: About you		
For faster payment, please complete this section.		
Your name (Last, First, MI)	Your e	employer
Your UnitedHealthcare Member Your mailing address (street ac		or your member website. Your Date of Birth MM/DD/YYYY
Part 2: About your expenses		
Complete the information below for each expense you're submitting. If you have more than four expenses, please print out multiple copies of this page and use this section as many times as needed.		
1 Expense 1 Dependent first name	Dependent last name	Dependent Date of Birth M M / D D / Y Y Y Y Dependent relation to you
Amount .	Start date of care or service	End date (may be the same as start date)
2 Expense 2 Dependent first name	Dependent last name	Dependent Date of Birth M M / D D / Y Y Y Y Dependent relation to you
Amount	Start date of care or service	End date (may be the same as start date)
3 Expense 3 Dependent first name	Dependent last name	Dependent Date of Birth M M / D D / Y Y Y Y Dependent relation to you
Amount .	Start date of care or service	End date (may be the same as start date)
4 Expense 4 Dependent first name	Dependent last name	Dependent Date of Birth M M / D D / Y Y Y Y Dependent relation to you
Amount	Start date of care or service	End date (may be the same as start date)

Part 3: Dependent Care Provider Information



Submit a separate form for each additional provider as necessary.

Provider name (Organization or Last, First, MI)

Provider address (street address, city, state, ZIP)

Part 4: Certification of Services OR Receipts

Now it's time to provide proof of the expenses. You can have the provider sign and fill in his or her job title under Certification of Services **OR** you can provide itemized receipts for each amount requested. If you do not provide one of these, your request will be denied.

Certification of Services

Provider signature

Provider job title

Receipts

The receipts you provide as proof for your expenses **must** show specific information:

For expenses:

- O Name and address of provider
- O Amount charged
- O Date of service
- O Dependent's name
- 1. Circle names and dollar amounts on your receipts.

 Don't write any information on the receipt.
- **2.** Use only blue or black ink. Don't use a highlighter.
- **3.** Tape small receipts to a sheet of 8.5 x 11 blank white paper.



Please don't send credit card receipts, cashed checks or copies of checks. They are not acceptable receipts for reimbursement.

Part 5: Certify and sign



Please reimburse me for the expenses I am submitting on this form. By signing below I certify (promise) that:

- ▶ The expenses I am submitting were spent by me or my spouse or eligible dependents;
- ► These are eligible expenses;
- These expenses have not been reimbursed before, and I will not ask for reimbursement from any other account;
- ▶ These expenses have not and will not be claimed as a federal income tax deduction or credit; and
- ▶ To my knowledge, the statements I have made on this form are true and complete.

Sign here

Date



Mail or fax pages 2 and 3 of this form along with your receipts*

Mail to: Health Care Account Service Center P.O. Box 981506 El Paso, TX 79998-1506

► Fax: (915) 231-1709 ► Toll-free fax: 1-866-262-6354



Copy your form and receipts* for your records before mailing.

* Receipts are only required if the provider does not sign the form in Part 4: Certification of Services.



