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.

Before you begin

Use **only** black or blue **pen** to fill out the form.

Have you moved? Be sure to let your employer or plan sponsor know your new address so you will receive your payment.

Need help?
Call us at 1-800-331-0480

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Please continue to the form on the next page.

Part 1: About you

For faster payment, please complete this section.

Your name (Last, First, MI)

Your employer

You can find these two numbers on your Health Plan ID Card or your member website.

Your UnitedHealthcare Member ID#

Your Group Number

Your Date of Birth MM / DD / YYYY

Your mailing address (street address, city, state, ZIP)

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 Date of Birth MM / DD / YYYY

Dependent first name

Dependent last name

Dependent relation to you

Amount , .

Start date of care or service MM / DD / 20YY

End date (may be the same as start date) MM / DD / 20YY

2 Expense 2

Dependent Date of Birth MM / DD / YYYY

Dependent first name

Dependent last name

Dependent relation to you

Amount , .

Start date of care or service MM / DD / 20YY

End date (may be the same as start date) MM / DD / 20YY

3 Expense 3

Dependent Date of Birth MM / DD / YYYY

Dependent first name

Dependent last name

Dependent relation to you

Amount , .

Start date of care or service MM / DD / 20YY

End date (may be the same as start date) MM / DD / 20YY

4 Expense 4

Dependent Date of Birth MM / DD / YYYY

Dependent first name

Dependent last name

Dependent relation to you

Amount , .

Start date of care or service MM / DD / 20YY

End date (may be the same as start date) MM / DD / 20YY

Continue to the next page.

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:

- ○ Name and address of provider
- ○ Amount charged
- ○ Date of service
- ○ 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 MM / DD / 20YY

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.

Need help?
Call us at 1-800-331-0480

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