


FSA HRA Claim for Reimbursement

 **TIME SAVING TIP:** Did you know you can file your claim online at optumbank.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.

Questions? Please call us at 1-800-243-5543 if you have any questions while completing this form.

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 eligible expense type. If you have multiple eligible 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 Claim for Reimbursement Forms as needed.

Health Care Expenses	Date of service MM/DD/YY <i>Example: 1/1/15 thru 1/31/15</i>	Expense Amount Claimed <i>Example: \$125.00</i>	Name of Person Receiving product or service <i>Example: John Doe</i>	Name of Service Provider <i>Example: ABC Insurance Co.</i>	Type of Expense (Medical, Vision, Premium, etc.) <i>Example: Insurance Premium</i>
EXPENSE ①		\$			
EXPENSE ②		\$			
EXPENSE ③		\$			
EXPENSE ④		\$			
EXPENSE ⑤		\$			

Dependent Care Expenses	Date of service MM/DD/YY	Expense Amount	Name of Service Provider	Dependent Receiving Service		Provider Certification <i>(in place of supporting documentation)</i>		
				Age	Name	Amount	Signature	Tax ID #
EXPENSE ①		\$				\$		
EXPENSE ②		\$				\$		
EXPENSE ③		\$				\$		

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 applicable benefit plan(s). All expenses I am submitting for reimbursement were incurred during a period I was covered by the company's applicable benefit plan(s). 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 this reimbursement submission.



Participant's Signature

Date



Don't forget to submit legible documentation for each expense along with this form. For dependent care expenses, you may complete the Provider Certification in Step 2 in lieu of documentation. All supporting documents must include the following:

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

Where to return your form and documentation?

By Mail: Optum Bank, P.O. Box 30516, Salt Lake City, UT 84130
 By Email: optumclaims@prod.sourcehov.com
 By Fax: 1-855-244-5016