UNIVERSITY OF ARKANSAS SYSTEM

UMR

See Reverse Side For Instructions

FLEXIBLE SPENDING ACCOUNT

EMPLOYEE INFORMATION (*Please Print*)

Name _____ Member ID or SSN _____

Home Address _____ Plan Year _____

City, State, Zip _____ Phone _____

Employer Location _____ E-mail _____

A. HEALTH CARE EXPENSES (Attach Supporting Documentation)

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Amount of Reimbursement Requested
		TOTAL HEALTH CARE EXPENSE		

B. DEPENDENT CARE EXPENSES (Attach Supporting Documentation)

Name of Dependent(s) and Age(s)	Service Date		Name, Address and Social Security Number Or Tax Identification Number of Provider of Service	Amount of Reimbursement Requested
	From	To		
		***TOTAL DEPENDENT CARE EXPENSE**		

I certify that I have provided dependent care as described on the back of this form and noted in (B) above. I have received $ _____ as payment for the services I rendered for the above service dates.

Social Security # or Taxpayer ID # of Provider **Signature of Dependent Care Provider**

EMPLOYEE SIGNATURE REQUIRED – *READ CAREFULLY*

The undersigned participant in the Flexible Spending Account (FSA) certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the FSA with respect to such expenses. The undersigned fully understands that he/she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned and that unless an expense for which payment or reimbursement is claimed is a proper expense under the FSA, the undersigned may be liable for payment of all related taxes including federal or state income tax on amounts paid from the FSA which relate to such expense. The undersigned also acknowledges that the reimbursements hereby requested have not been and are not reimbursable under any other coverage. I have read and understand the important information on the reverse side of this form.

Employee's Signature **Date**

Send this form and supporting documentation to: **Phone: 888-438-6105**

Fax: 877-390-4782, E-mail: umr-fsa@umr.com , or Mail: UMR, PO BOX 8022, Wausau, WI 54402-8022

IMPORTANT INFORMATION REGARDING REIMBURSEMENTS

Eligible Health Care Services and Documentation Requirements:

The expense must be a health-related expense incurred by you or one of your tax 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 indicated and not for cosmetic purposes or general good health. A listing of eligible and ineligible expenses can be found online at www.umr.com

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

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

Eligible Dependent Care Services and Documentation Requirements:

The expense must be a dependent care-related expense incurred by you for one or more of your eligible dependents. This means amounts paid for the care of your qualified dependent so you and your spouse can work or look for work. A listing of eligible and ineligible expenses can be found online at www.umr.com

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

DO	DO NOT
➢ Submit services after they have been incurred. ➢ Have the day care provider sign the front of the claim form if the services have been incurred to eliminate the need to send any other documentation. ➢ Complete the total requested amount ➢ Send the documentation on white paper. Carbon copies and colored paper are not legible when scanned. ➢ Tape small receipts to a standard 8.5" x 11" sheet of blank paper. Ensure print is legible. ➢ Make a copy of the form and documentation for your personal records.	➢ Do not submit balance forward statements. ➢ Do not submit bank statements ➢ Do not highlight names, prices or dates on receipts. They are not legible when scanned.

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.

Web Claim Submission allows you to submit your claim online at www.umr.com. Please print the cover sheet and fax it along with your documentation to 866-881-1200.

Fax Verification is available by calling 888-438-6105 and following the appropriate prompts. The Interactive Voice Response (IVR) system can verify faxes received within the last 30 days.

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. If you are not sure if a service or item will be covered, please contact UMR customer service.

Limitations on Reimbursement of Over-the-Counter Supplies (Stockpiling) will be followed. 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).

Payments are issued once the total reimbursement amount reaches your plan's $10.00 check minimum.