FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM

Please complete the information on this form and review the following reminders:

- ☐ Is your Subscriber ID number (if you are a UHC Plan member) or your Social Security number or Team Member ID number (if you are a non-UHC plan member) included on the form? If you are a UHC plan member, you can find your Subscriber ID number on your ID card.
- ☐ Is your total requested amount included on the form?
- ☐ Did you attach copies of your itemized documentation with your request?
- ☐ Did you sign and date the bottom of this form? If not, your request will be denied.
- ☐ Have you made copies of your request for your own personal records?

DOCUMENTATION

The following are examples of eligible supporting documentation that should be submitted with your request. A cancelled check is not adequate documentation. Please note: your FSA may not provide reimbursement of all expenses below. Refer to your Summary Plan Description (SPD) for specific terms. Do not submit this form if the expense will automatically be reimbursed through the automatic submission and payment process. Small receipts should be taped to a standard 8.5" x 11" sheet of blank paper and must be legible when scanned.

Medical, Dental, Vision and Hearing Expenses

For expenses partially covered by any medical, dental or vision insurance plan, you must submit an explanation of benefits (EOB) or monthly statement with your completed claim form. You may submit a copay receipt if this is your only expense.

For expenses not covered by any medical, dental or vision insurance plan, you must submit the following information:

- Name and address of the provider
- Dates of service
- Dollar amount charged
- Patient's name
- Type of service

Prescription Drugs

The prescription name or NDC#, date the prescription was filled, patient name and cost should be included on the receipt. This information can usually be found on the prescription tags provided by the pharmacy.

Over-the-Counter (OTC) Drugs

When submitting a receipt for an over-the-counter expense, fill in "pharmacy" for the type of service on the claim form. A printed receipt must include the name of the over-the-counter item, the price and the date purchased. Handwritten over-the-counter item names on register receipts are unacceptable. The name of the item(s) and price(s) must be circled on the receipt. Receipts should be taped to a standard 8.5" x 11" sheet of blank paper. Receipts must be legible when scanned.

Using the FSA with the HSA Plan

If you enrolled in the HSA Plan, you have a limited use FSA. During the deductible, you may submit a reimbursement form for eligible dental and vision expenses only. You may not use FSA dollars to help meet your deductible. After the deductible is met, you may use your FSA for health care expenses such as your coinsurance.

RETURN THIS FORM TO:
Health Care Account Service Center
PO Box 981506
El Paso, TX 79998-1506
Fax: (915) 231-1709
Phone: (888) 444-4314

FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM

Please read these instructions before completing your FSA withdrawal request.

1. Team member must complete Part 1. **UHC plan members:** Be sure to enter your subscriber ID (on your ID card). **Non-UHC plan members:** Be sure to enter either your Social Security number or your Target Team Member ID.
2. Instructions for Part 2:
   a. If expenses were covered by any benefit plan, attach a copy of the Explanation of Benefits (EOB) along with this form. Your insurance carrier (or a spouse's carrier or an individual plan) should pay before you request an FSA reimbursement.
   b. If expenses are not covered by any benefit plan, attach a copy of an itemized receipt that includes the dates of service, service rendered and total charge.
3. Read the Certification For Reimbursement, sign and date the form. Make a copy for your records.
4. Mail (or fax) the form to the address (or fax number) provided on this form. All reimbursement requests for a plan year made during the following year must be postmarked prior to the filing deadline, which is specified in your plan documents.

PART 1 – Team Member Information (PLEASE PRINT)

TEAM MEMBER'S NAME LAST	FIRST	MIDDLE	FSA GROUP NUMBER
			709018
STREET ADDRESS			**UHC PLANS:** SUBSCRIBER ID (ON ID CARD) **NON-UHC PLANS:** SSN OR TEAM MEMBER ID
CITY	STATE	ZIPCODE	DAYTIME PHONE NUMBER
		-	( ) -

Employer's Name

Target

PART 2 – Flexible Spending Account for health care (PLEASE PRINT)

Date(s) of Service (MM/DD/YYYY) From	To	Name of Person Receiving Service	Type of Service/Supply Provided (Medical, Pharmacy, Vision, Dental, Hearing)	Expense Incurred
				$
				$
				$
				$
				$
			TOTAL	**$**

Don't forget to attach documentation for each expense.

PART 3 – Certification For Reimbursement

I certify that any expenses for which I am requesting reimbursement from my FSA, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) for medical care as permitted under the FSA, and have not been and will not be reimbursed by any other plan.

I understand that expenses reimbursed through the FSA program cannot be used to claim any Federal income tax deduction or credit. To the best of my knowledge and belief, my statements on this form are complete and true.

TEAM MEMBER SIGNATURE	DATE

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