UnitedHealthcare

Retiree Claim for Reimbursement

TIME SAVING TIP: Did you know you can file your claim online at **uhcretireeaccounts.*com*** *instead of completing this form? Simply log into your account and click "File A Claim" under the "I Want To," section on the home page.*

Questions? Please call us at 1-877-298-2305 if you have any questions while completing this form.

1012 RRA UHC

1 Participant information

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 *Example: 1/1/120 thru 1/31/20*	Expense amount claimed *Example: $125.00*	Name of person receiving product or service *Example: John Doe*	Name of service provider *Example: ABC Insurance Co.*	Type of expense (medical, vision, premium, etc.) Example: Insurance premium
EXPENSE ❶		$			
EXPENSE ❷		$			
EXPENSE ❸		$			
EXPENSE ❹		$			
EXPENSE ❺		$			

3 Agreement and participant 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 retiree plan, which is a health reimbursement arrangement (HRA). All expenses I am submitting for reimbursement were incurered during a period I was covered by the company's retiree plan, which is an HRA. 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

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

Where to return your form and documentation?

By mail: UnitedHealthcare, P.O. Box 30516, Salt Lake City, UT 84130
By email: optumclaims@optumbank.com
By fax: 1-844-822-2881
Note: Forms without a signature will not be processed.

RRAs are administered by Optum Financial.