UnitedHealthcare

Dependent Care Claim Form

MAIL CLAIM FORM TO:

Health Care Account Service Center
PO Box 981506
El Paso, TX 79998-1506
Fax: 915-231-1709 Toll Free Fax 866-262-6354
Customer Service 800-331-0480

Complete Part 1 entirely and legibly. If you do not know your Participant ID, Group Number or a have a change of address please contact your Human Resources Representative.
Complete Part 2 with your Dependent Care expenses. Carefully read and follow the directions below regarding the Provider's Certification of Services Rendered.

DO

- Complete the total requested amount.
- Send original copies on white paper. Carbon copies and colored paper are not legible when scanned.
- Circle names and dollar amounts on receipts.
- Tape small receipts to a standard 8.5" x 11" sheet of blank paper. Ensure print is legible.
- Attach itemized receipts/documentation to the form.
- Read Certification for Reimbursement, sign and date form.
- Make a copy of form and documentation for your personal records.

DO NOT

- Do not submit cancelled checks or credit card receipts alone. These are *not* adequate documentation without supporting itemization.
- Do not highlight names, prices or dates on receipts. They are not legible when scanned.
- Do not handwrite item names on receipts. These are not acceptable.

Dependent Care Services, if all four fields in the Day Care Provider's Certification section are completed, no further documentation is necessary. In lieu of the above, you may submit a statement from the provider that includes:

*Provider's name *Tax identification or social security number (optional) *Dates of service
*Cost of service *Provider's Signature

Mail (or fax) the form and required documentation to the address (or fax number) provided on this form.
Please refer to your plan document for dependent care related services that may not be covered under your specific FSA plan.

A general list of eligible/non-eligible items along with frequently asked questions are available on line at www.myuhc.com. However, you should refer to your specific FSA plan document for information relating to the dependent care expenses that are reimbursable through your plan.

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Part 1 Employee Information (Please Print) Please read the instructions on reverse in their entirety before completing form.

Employee Name (Last and First)	**Member ID** (SSN)	Date of Birth	Daytime Telephone No
Mailing Address Please notify your Human Resource Representative of any address changes.		FSA Group #	Employer Name

Part 2 Dependent Care Expenses (Please Print). Itemize **each** expense using a separate line. Use additional forms as necessary.

Dependent/Child's Name	Relationship	Date of Birth mm/dd/yyyy	Type of Dependent/Child Care Service	Date(s) of Service mm/dd/yyyy		Request Amount
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
			Total Request For Reimbursement			$

Day Care Provider's Certification of Services Rendered (PLEASE PRINT)
I, the signer below, certify that the services listed in Part 2 above, have been incurred and were rendered by me.

Day Care Provider and Company Name:	Day Care Provider's Address:
Day Care Provider's Tax Id# (optional):	Day Care Provider's Signature and Title:

Certification For Reimbursement
I certify that any expenses for which I am requesting reimbursement from my Dependent Care FSA, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) for dependent care as permitted under the Dependent Care FSA, and have not been reimbursed and I will not seek reimbursement under 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 are complete and true. I agree that by submitting this claim for reimbursement, I am agreeing to these certification terms.

EMPLOYEE SIGNATURE:_____**DATE:**_____