

HEALTH CARE EXPENSE CLAIM FORM

Mail to:
UPMC Health Plan
PO Box 3169
Greenwood Village, CO 80155-3169

Phone: 1-888-876-2756
Fax: 1-866-229-3711

No. of pages _____

PLAN & EMPLOYEE INFORMATION

FIRST NAME: _____ LAST NAME: _____ MEMBER ID NUMBER: _____

DAYTIME PHONE: () _____ EMAIL: _____ DATE OF BIRTH: ____/____/____

EMPLOYER NAME: **UPMC** PLAN YEAR: _____

Note: Reimbursements will be sent to the address on file with UPMC. If an address change or update is needed, please contact your Human Resources office or update your information via My HUB.

HEALTH CARE EXPENSES

»»» DO NOT INCLUDE RECEIPTS FOR EXPENSES YOU PAID FOR WITH YOUR BENEFIT PAYMENT CARD.
»»»DO NOT HIGHLIGHT RECEIPTS OR ITEMS ON THIS FORM IF YOU WILL BE FAXING OR SUBMITTING ELECTRONICALLY.

UPMC has adopted the grace period (IRB 2005-42). Expenses incurred during that period (75 days after the plan year ends) are eligible for reimbursement from either the current or previous FSA plan year. If you are seeking reimbursement for expenses incurred within that period, please mark one of the boxes below to indicate the plan year from which you would like to be reimbursed. If you do not mark one of the boxes, your claim will be applied to the previous plan year first and then the current plan year if applicable.

Reimburse from previous plan year Reimburse from current plan year

SERVICE DATE	SERVICE PROVIDER	EXPENSE DESCRIPTION	RECIPIENT OF SERVICE	RELATIONSHIP TO EMPLOYEE	\$ AMOUNT
					\$
					\$
					\$
					\$
					\$
					\$
					\$
TOTAL EXPENSES					\$

REIMBURSEMENT INFORMATION

- Please pay this claim by direct deposit to my specified account already on file.
- Please pay this claim by direct deposit using the new information provided below.
- Please issue a check for this claim.

I hereby authorize UPMC Health Plan, Inc. and authorities on its behalf to initiate credit entries for my Flexible Spending Account reimbursements into my account designated below and, if necessary, make corrections for any entries made in error. This authority is to remain in full force and effect until UPMC Health Plan, Inc. has received written notification from me of its cancellation in such time and in such manner as to afford UPMC Health Plan, Inc. a reasonable opportunity to act.

ACCOUNT NUMBER: _____ ROUTING NUMBER: _____

BANK NAME: _____ CHECKING ACCOUNT SAVINGS ACCOUNT

Must be 9 digits

EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the expenses listed above are accurate, complete and are eligible for reimbursement under the plan. I certify that these expenses will not be claimed again when filing IRS form 1040 and that they were incurred for me or my eligible dependents. I certify that these health care expenses have not already been reimbursed under this plan or any other plan and are not reimbursable under any other coverage or employer plans. I certify that if my employer incurs a liability for failure to withhold Federal, State or local, or Social Security Taxes on one or more of my payments or reimbursements that are not Qualified Expenses, I will indemnify and reimburse the employer that liability on demand. I further certify that the over-the-counter expenses claimed above are to alleviate or treat injuries or illnesses and will not be used for cosmetic purposes or for general good health.

Signature: _____ Date: _____