



Medical/Pharmacy
Health Reimbursement
Account Claim Form



Part A:
PERSONAL INFORMATION

Last Name	First Name	Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Member ID Number	Name of Employer	
<input type="text"/>	<input type="text"/>	

Part B:
REIMBURSEMENT INFORMATION

Service Date from	Service Date to	Reimbursement Requested
<input type="text"/>	<input type="text"/>	\$ <input type="text"/> . <input type="text"/>
Provider Name	Type of Service*	
<input type="text"/>	<input type="text"/>	
Service Date from	Service Date to	Reimbursement Requested
<input type="text"/>	<input type="text"/>	\$ <input type="text"/> . <input type="text"/>
Provider Name	Type of Service*	
<input type="text"/>	<input type="text"/>	
Service Date from	Service Date to	Reimbursement Requested
<input type="text"/>	<input type="text"/>	\$ <input type="text"/> . <input type="text"/>
Provider Name	Type of Service*	
<input type="text"/>	<input type="text"/>	
		Total Reimbursement
		<input type="text"/> . <input type="text"/>

Part C:
Attach **COPY** of itemized receipts.

* Be specific with the type of service

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- They were incurred for services or supplies received by my eligible dependents or me under the plan.
- They were for services or supplies furnished on or after the effective date of my employee reimbursement account.
- I have not been reimbursed for these expenses in any other way or from any other source.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered.

I further certify that I have not deducted nor will I deduct on my individual tax return any of the expenses reimbursed through my health care reimbursement account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept sole responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability. UMR shall not be liable for any penalties or damages as a result of an inappropriate claim filed by me. I will retain a copy of this form and all original receipts for my records.

Employee Signature	Date
<input type="text"/>	<input type="text"/>

FAX TO: 877-293-4911 SEND TO: UMR ² PO Box 30541, Salt Lake City, UT 84130 INQUIRIES: www.umar.com ² 1-800-826-9781
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