OPTUM Financial™

Manual Claim Form

Use this form to submit your claims for reimbursement of eligible expenses paid out of pocket that have not already been submitted.

- Do not use this form if expenses were already paid with your health care payment card.
- Do not use this form if you already submitted this claim using the mobile app or online.
- Complete all entries on this submission form. Please print or type.
- Sign and date this form.
- Fax or mail it, along with the required documentation, to the claims department. (See submission instructions below.)

Personal Information

Name of Employer:	
Employee Name: (last name, first name)	Last 4 Digits of Social Security Number:

Documentation Required

You must submit documentation with this form. Documentation must include the patient's name, description of service, date of service and amount charged. Cancelled checks, credit card documentation or balance forward statements are not acceptable. Examples of acceptable documentation include a copy of the Explanation of Benefits (EOB) from your insurance company, an itemized statement from a provider, or an itemized pharmacy receipt (if applicable to your plan).

Claim Details

Date of Service	Patient's Name*	Relationship to Employee	Name of Provider	Description of Service	Amount Requested
				Total	$

Authorization and Certification

***Read carefully: This claim will not be processed without your signature*.**

I certify that these expenses have been incurred by me or by my eligible spouse or dependent* as defined by my Plan and relevant IRS guidelines. The expenses have not been reimbursed and are not reimbursable under any other plan, such as a group medical plan, individual policy, or spouse's or dependent's plan. I understand that any amount reimbursed may not be used to claim any federal income tax deduction or credit on my or my spouse's or my dependent's income tax return. I understand that it is my responsibility to determine whether distributions are for qualified expenses and for any tax consequences that may occur. *If I am participating in an HRA, I certify that any medical expenses have been incurred by me or by my eligible spouse or dependent covered by my medical plan.

Signature _____ Date _____

Submission Instructions

For fastest results, fax to: (443) 681-4602	Or mail to: **Claims Department** P.O. Box 622317 Orlando, FL 32862-2317

* Patient/dependent must be eligible for reimbursement under your plan and relevant IRS guidelines.

FSAs and HRAs are administered by Optum Financial.

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