Mail to:

United Medical Alliance
FSA Department
2021 Battlecreek Drive, Suite A
Fort Collins, CO 80528
970-224-4600

United Medical Alliance
FSA Claim Form

Fax to:

United Medical Alliance
FSA Department
2021 Battlecreek Drive, Suite A
Fort Collins, CO 80528
970-224-3722

Employee Name: _____ Social Security Number: _____

Employer Name: _____

Health Care Claims (for you or your dependents)
Covered by Insurance - Expenses for services or items must be submitted to your insurance company before submitting for reimbursement under your flexible spending account. When you receive the explanation of benefits (EOB) from your insurance company, include a copy with this completed claim form. If you have a copay, attach an itemized statement from your provider.
Not Covered by Insurance - For services or items not covered by insurance, submit an itemized statement from the provider, showing the provider's name/address, patient name, date of service, description of service and amount paid, along with this completed claim form. Balance forward statements, cancelled checks, credit card receipts or received on account statements are not acceptable.
Prescription and over the counter drugs and medicines require a print-out of prescriptions from your pharmacy or must be clearly identifiable on an itemized receipt. Quantities purchased must be reasonably able to be consumed during the current plan year. Items for maintaining general good health, cosmetic purposes and dietary supplements are not eligible.

Date of Service	Type of Service (Ex. - RX, OTC, Medical, Dental etc.)	Amount Requested		Date of Service	Type of Service (Ex. - RX, OTC, Medical, Dental etc.)	Amount Requested
					Total	

Dependent Child or Adult Day Care Claims
Complete this form and attach an itemized statement from your day care provider or have your provider complete the information below. IRS regulations allow payment for services that have already been provided, not for services to be provided in the future. (IRS regulations require you to report the provider's name, address and TAX Identification Number on Form 244) with your personal income tax return. If your day care provider completes and signs this form below, no other itemized statement is necessary.

Exact Dates of Service		Dependent Name	Age	Amount Requested
From	To			

Care Provider Information _____
Name _____
Address _____
Provider Signature _____

(This claim will not be processed without your signature.) I certify that these eligible expenses have been incurred by me or my eligible dependent and are not for cosmetic purposes but for the treatment of an illness, injury, trauma or medical condition. I understand the expense incurred means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed and I will not seek reimbursement elsewhere. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature _____ Date _____

Make copies for yourself, these documents will not be returned