



HEALTH CARE SPENDING ACCOUNT CLAIM FORM

All claims must be submitted with supporting documentation containing the following: **name of patient, name of provider, expense incurred (type of service), date of incurred expense (the date the service is provided, not when the expense is paid), and amount of expense.** If the request is for an over-the-counter drug, you must indicate the drug and its purpose to treat the patient.

Group #	Employer's Name		
Employee's Name		Social Security Number	
Employee's Address (Number & Street)		Is this a new mailing address? () YES () NO	
(City, State, Zip)		Employee's Date of Birth	
Daytime Phone Number (please include area code)	Fax Number (please include area code)	Employee's E-Mail Address	

Date of Services m/d/y to m/d/y	Expenses For		Description of Service (i.e., medical, dental, vision, Rx)	Over-the-Counter (OTC) Drug Name	OTC Drug - Purpose to treat patient (allergies, sickness, etc.)	Amount of Reimbursement Request
	Patient Name	Relationship				
/ / to / /						
/ / to / /						
/ / to / /						
/ / to / /						
/ / to / /						

Total Amount Requested from my Health Care Account: \$_____.

- I certify that:
- | | |
|---|---|
| <ol style="list-style-type: none"> 1. The above listed have been incurred by me or my eligible dependents (as defined by the IRS). 2. The above listed are not reimbursable under any other employer sponsored health plan. 3. Listed over-the-counter drugs are to treat a medical condition. | <ol style="list-style-type: none"> 4. I will not deduct these reimbursements on my individual Federal Income Tax Return. 5. I will assume all responsibility for taxes or penalties arising out of any disallowed deductions. |
|---|---|

Employee Signature (You must sign this to be reimbursed.) _____

Signature _____ Date _____

Send this form, along with all supporting documentation* to:
(Be sure to keep copies for your records.)

UNICARE
Flexible Benefits Department
P.O. Box 4465

* **Supporting documentation** includes bills, itemized statements, and Explataion of Benefit Statements. **Chicago, IL 60680-4465**
* *Cancelled checks **are not** acceptable forms of documentation.**

If you have any questions regarding your Health Care Spending Account, you may call the Flexible Benefits Department at (800) 844-2946