UNIVERSITY of COLORADO HEALTH
UCHEALTH PLAN ADMINISTRATORS

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

☐ Healthcare Spending Account
☐ Dependent Care Spending Account

Employee Name	Employer Name	Last 4 Digits of SSN	Date of Birth

Healthcare Claims (for you and/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, and a 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 medications 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 expenses.

Date of Service	Type of Service (Rx, 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 provide completes and signs this form, no other itemized statement is necessary.

Dates of Service	Dependent Name	Age of Dependent	Amount Requested
TOTAL			

Dependent Care Provider Information

Name	Address	Provider Signature

I certify that these eligible expenses have been incurred by me or my eligible dependent(s) 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 income tax returns (or my spouse's income tax returns, if applicable). I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature	Date

Please submit claims to:
UCHealth Plan Administrators
1024 S. Lemay Ave.
Fort Collins, CO 80524
Fax: (970) 224-3722
Email: fsa@uchealth.org