

## ICHRA Claim for Reimbursement

Use this form to submit claims for reimbursment for individual coverage health reimbursement arrangement (ICHRA).

Questions? Please call us at 1-800-243-5543 if you have any questions while completing this form.

About your expenses  Jee one line in this section for each eligible expense type. If you have multiple eligible expenses of the same type, for example copays, you may equest payment on one line for the entire date range. If you have more eligible expenses than space allows in this section, please submit as michaim for Reimbursement forms as needed.  **Page 1.5 Date of service   MM/DD/YY   Expense amount   Name of person receiving product or service   Example:   Example	,			Last 4 of SSN:		Emplo	ver/plan sponsor name	:
Use one line in this section for each eligible expense type. If you have multiple eligible expenses of the same type, for example copays, you may request payment on one line for the entire date range. If you have more eligible expenses than space allows in this section, please submit as microlaim for Relimbursement forms as needed.    Date of service   MM/DD/YY   Expense amount   Name of person   Name of service   provider   premium, etc.   Example:   Exampl				2030 1 01 33111		2	, e., p.a sponsoae	•
Health care expenses    MM/DD/YY   Claimed   Service   Example:	Participant address:				City, State ZIP:			
request payment on one line for the entire date range: If you have more eligible expenses than space allows in this section, please submit as miclaim for Reimbursement Torms as needed.    Page	2 About your	expenses						
Health care expenses    MM/DDYY   Claimed   Seximple: Example: Insurance Co.   EXPENSE	request payment on o	ne line for the entire da	pense type. I te range. If yo	If you have mu ou have more	ultiple eligible expens eligible expenses tha	es of the n space	same type, for examp allows in this section, p	le copays, you may olease submit as man
EXAMPLE: Lexample: Lexampl		MM/DD/YY			receiving product or service Example:			Type of expense (medical, vision, premium, etc.)
EXPENSE  \$  EXPENS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•	· ·				'	Example: Insurance Premium
EXPENSE  \$  EXPENSE  \$  S  EXPENSE  \$  S  S  EXPENSE  \$  S  S  EXPENSE  \$  S  Required premium expense documentation  Please provide copies of documentation for the premiums that are eligible for reimbursement. If we are unable to read the documents to the quality of the copy, we may need to request additional information. Here are some examples of acceptable supporting documentation folian premiums:  Insurance premium confirmation letter  Insurance premium payment coupon  Monthly or quarterly billing statement  Bank statement showing premium deduction (electronic withdrawal)  Annual statement from Social Security Administration (if plan allows Medicare Part B and/or D reimbursement)  4 Attestation of coverage and participant signature  By submitting this form, I certify that: I, as the individual or on whose behalf the reimbursement is requested is (or was) enrolled in individual here insurance coverage or Medicare Part A and B or Medicare Part C for the month during which the medical care expense was incurred. Furtherms all expenses I am submitting for reimbursement were incurred by me or another individual eligible under my company's applicable benefit plan(s). None the expenses I am submitting for reimbursement were incurred during a period I was covered by the company's applicable benefit plan(s). None the expenses I am submitting for reimbursement was been reimbursed by or, if applicable to my plan, are reimbursable from any other source. am fully responsible for the sufficiency and accuracy of information relating to this reimbursement submission.  Lattest to the following:	EXPENSE <b>0</b>		\$					
S  Required premium expense documentation  Please provide copies of documentation for the premiums that are eligible for reimbursement. If we are unable to read the documents to othe quality of the copy, we may need to request additional information. Here are some examples of acceptable supporting documentation for the premiums:  Insurance premium confirmation letter  Insurance premium payment coupon  Monthly or quarterly billing statement  Bank statement showing premium deduction (electronic withdrawal)  Annual statement from Social Security Administration (if plan allows Medicare Part B and/or D reimbursement)  Attestation of coverage and participant signature  Sy submitting this form, I certify that: I, as the individual or on whose behalf the reimbursement is requested is (or was) enrolled in individual here.  Survance coverage or Medicare Part A and B or Medicare Part C for the month during which the medical care expense was incurred. Furtherms all expenses I am submitting for reimbursement were incurred by me or another individual eligible under my company's applicable benefit plan(All expenses I am submitting for reimbursement were incurred during a period I was covered by the company's applicable benefit plan(All expenses I am submitting for reimbursement were incurred during a period I was covered by the company's applicable benefit plan(S). None the expenses I am submitting for reimbursement were incurred during a period I was covered by the company's applicable benefit plan(S). None the expenses I am submitting for reimbursement have been reimbursed by or, if applicable to my plan, are reimbursable from any other source. am fully responsible for the sufficiency and accuracy of information relating to this reimbursement submission.  attest to the following:  Am requesting reimbursement for a medical care expense incurred during, and for that mo am (or was) covered under the following health coverage:  Complete the following if you're requesting reimbursement of a family member's medical care	EXPENSE 2		\$					
Required premium expense documentation  Please provide copies of documentation for the premiums that are eligible for reimbursement. If we are unable to read the documents to to the quality of the copy, we may need to request additional information. Here are some examples of acceptable supporting documentation for oblan premiums:  Insurance premium confirmation letter Monthly or quarterly billing statement for a medical training statement submission.  Monthly or quarterly billing statement for a medical care expense incurred during, and for that monthly during for reimbursement for a medical care expense incurred during, and for that monthly during for primbursement for a medical care expense incurred during, and for that monthly during health coverage:,  Monthly or quarterly billing statement for a family member's medical care expense from the individual coverage in th	EXPENSE 🔞		\$					
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Please provide copies of documentation for the premiums that are eligible for reimbursement. If we are unable to read the documents of the quality of the copy, we may need to request additional information. Here are some examples of acceptable supporting documentation for olan premiums:  Insurance premium confirmation letter Insurance premium payment coupon Monthly or quarterly billing statement Bank statement showing premium deduction (electronic withdrawal) Annual statement from Social Security Administration (if plan allows Medicare Part B and/or D reimbursement)  Attestation of coverage and participant signature By submitting this form, I certify that: I, as the individual or on whose behalf the reimbursement is requested is (or was) enrolled in individual head in submitting for reimbursement were incurred by me or another individual eligible under my company's applicable benefit plan (all expenses I am submitting for reimbursement were incurred by me or another individual eligible under my company's applicable benefit plan (all expenses I am submitting for reimbursement were incurred during a period I was covered by the company's applicable benefit plan(s). None he expenses I am submitting for reimbursement have been reimbursed by or, if applicable to my plan, are reimbursable from any other source. In fully responsible for the sufficiency and accuracy of information relating to this reimbursement submission.  Attest to the following:  Am requesting reimbursement for a medical care expense incurred during medical care expense from the individual coverage incurred during medical care expense from the individual coverage.  Complete the following if you're requesting reimbursement of a family member's medical care expense from the individual coverage.	EXPENSE <b>⑤</b>		\$					
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Date: \_



## ICHRA Claim for Reimbursement



Don't forget to submit legible documentation for each expense along with this form. All supporting documents must include the following:

- 1. Total expense amount
- 2. Description of expense
- 3. Date expense was incurred
- 4. Name of person receiving service
- 5. Name of person/entity providing service
- 6. Attestation

Where to return your form and documentation?

By mail: Optum Bank, P.O. Box 30516, Salt Lake City, UT 84130 By email: optumclaims@optumbank.com

By fax: 1-844-822-2881

Note: Forms without a signature will not be processed