OPTUM Financial™

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.

1012 HA ICHRA

1 Participant information

First name, last name:	Last 4 of SSN:	Employer/plan sponsor name:
Participant address:	City, State ZIP:	

2 About your expenses

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 many Claim for Reimbursement forms as needed.

Health care expenses	Date of service MM/DD/YY *Example: 1/1/20 thru 1/31/20*	Expense amount claimed *Example: $125.00*	Name of person receiving product or service *Example: John Doe*	Name of service provider *Example: ABC Insurance Co.*	Type of expense (medical, vision, premium, etc.) Example: Insurance Premium
EXPENSE ❶		$			
EXPENSE ❷		$			
EXPENSE ❸		$			
EXPENSE ❹		$			
EXPENSE ❺		$			

3 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 due to the quality of the copy, we may need to request additional information. Here are some examples of acceptable supporting documentation for plan 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 health insurance coverage or Medicare Part A and B or Medicare Part C for the month during which the medical care expense was incurred. Furthermore, all expenses I am submitting for reimbursement were incurred by me or another individual eligible under my company's applicable benefit plan(s). All expenses I am submitting for reimbursement were incurred during a period I was covered by the company's applicable benefit plan(s). None of the expenses I am submitting for reimbursement have been reimbursed by or, if applicable to my plan, are reimbursable from any other source. I am fully responsible for the sufficiency and accuracy of information relating to this reimbursement submission.

I attest to the following:
I, _____, am requesting reimbursement for a medical care expense incurred during _____, and for that month I 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 from the individual coverage HRA (ICHRA).
I, _____, am requesting reimbursement for a medical care expense incurred by _____, during _____, and for that month this family member is (or was) covered under the following health coverage: _____.

I hereby affirm that the above information is true and accurate.

Signed: _____

Date: _____

FSAs and HRAs are administered by Optum Financial.

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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

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