OPTUM®

Recurring Orthodontia Reimbursement Request

Please complete this form to establish a Recurring Orthodontia Reimbursement Request. If your provider contract extends past the current plan year and you wish to have the remaining payments reimbursed in a subsequent plan year, you will need to be actively enrolled in an FSA or HRA Plan. In addition, you must send in a new Recurring Orthodontia Reimbursement Request Form for the new plan year. Customer service professionals can be reached by calling 1-800-243-5543 (Monday - Friday from 8 a.m. to 10 p.m. and Saturday - Sunday from 9 a.m. to 5:30 p.m. Eastern time) if you have any questions while completing this form.

1017 HA FSA HRA

1 Participant Information

Participant Name:	Last 4 of SSN:
Employer/Plan Sponsor Name:	Provider Name:
Name of Dependent Receiving Services:	

2 Information about your Recurring Reimbursement Request

Please provide the information below about your recurring reimbursement request:

1. Which months would you like to be reimbursed? _____ through _____
   (Month/Year – Example: Jan 2017) (Month/Year – Example: Dec 2017)
2. What is the amount you would like to be reimbursed each month? $ _____

Important Note: The amount you are reimbursed each month cannot exceed your monthly contract payment amount. The amount you request each month will be deducted from your HRA or FSA until one or more of the following happen:

- Your available funds are used up
- The calendar year ends
- You drop/add/change your existing coverage
- You notify Optum in writing to stop the monthly recurring reimbursements

3 Required 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:

- Provider contract/treatment plan
- Payment coupon from Coupon Booklet
- Explanation of Benefits (EOB)
- Provider Statement

4 Participant Signature

By signing below, I certify that all expenses I am submitting for reimbursement were incurred by me, or another individual eligible under my company's FSA or HRA Plan, that the expenses were incurred during a period I was covered by the company's Plan, and that none of the expenses have been reimbursed by or, if applicable to my Plan, are reimbursable from any other source. I understand that I am responsible for the accuracy of information relating to the reimbursement submission, and that if an expense claimed is subsequently determined to be ineligible under my Plan, I may be liable for repayment to the Plan and payment of all related taxes, including federal, state, or local income tax, on amounts paid from the Plan. I acknowledge and agree that I have had an opportunity to consult with my tax advisor prior to submitting this form. If I participate in a group health plan that does not provide *Minimum Value*, as defined by the IRS, I certify that expenses I submit for reimbursement under my HRA are limited to copayments, coinsurance, deductibles, premiums under the non-HRA group coverage and medical care that does not constitute essential health benefits, as defined by the Affordable Care Act and applicable state law. I agree to consult my plan sponsor to determine if their Plan provides *Minimum Value*.

x _____ _____

Participant Signature Signature Date

Thank you for allowing us to serve you.

Where to return your form?

By Mail: Optum, P.O. Box 30516, Salt Lake City, UT 84130
By Email: optumclaims@prod.sourcehov.com
By Fax: 1-855-244-5016