HEALTH CARE & DEPENDENT CARE REIMBURSEMENT REQUEST

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

EMPLOYEE INFORMATION

NAME:	**UMR MEMBER ID/SSN #:**	**PHONE #:**
☐ **CHECK HERE IF NEW ADDRESS**	**EMPLOYER NAME:**	
ADDRESS:	**EMAIL ADDRESS:**	
CITY:	**STATE:**	**ZIP:**

REIMBURSABLE EXPENSES

DATES OF SERVICE - (MM/DD/YY)		PROVIDER OF SERVICE	PERSON FOR WHOM SERVICE WAS PROVIDED	EXPENSE TYPE*	REIMBURSEMENT AMOUNT REQUESTED
Start Date	End Date	*If Dependent Care service, SSN or ID number must be included.			
					$
					$
					$
					$
					$
					$
					$
* Expense Type: M= Health Care / D= Dependent Care				TOTAL:	$

CERTIFICATION

I certify the following is true:

1. The expenses listed above were incurred by me and/or my eligible dependents and qualify for reimbursement.
2. The expenses listed above are not eligible for reimbursement by any health care plan.
3. I have not and will not deduct the above listed expenses on my Federal Income Tax returns.
4. The appropriate bills, receipts, Explanation of Benefit statements or documentation for dependent care expenses are attached or verified by provider signature below.

Employee Signature:	**Date:**
Provider of Dependent Care must certify dates and amounts listed above are correct for services rendered. **Provider Signature:** **Provider Tax ID:**	**Date:**

Any person who knowingly and with intent to defraud or deceive any health care plan, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

PLEASE SEND COMPLETED FORM TO:

MAIL: UMR
P.O. Box 8022
Wausau, WI 54402-8022

E-MAIL: umr-fsa@umr.com

FAX: 877-390-4782 -OR- 866-881-1200

FOR MORE INFORMATION ABOUT YOUR ACCOUNT, PLEASE VISIT OUR WEBSITE:
www.umr.com

CUSTOMER SERVICE
1-888-763-8232