OPTUM Financial™ TIAA

Claim form

Use this form to submit your claims for reimbursement of eligible expenses paid out of pocket that have not already been submitted.

- Do not use this form if expenses were already paid with your healthcare payment card.
- Do not use this form if you already submitted this claim online.
- Complete all entries on this submission form. Please print or type.
- Sign and date this form.
- Fax or mail it, along with the required documentation, to the claims department. (See submission instructions below.)

Personal information	
Name of employer	
Employee name (last name, first name)	Social Security Number

Documentation required

You must submit documentation with this form. Documentation must include the patient's name, description of service, date of service and amount charged. Cancelled checks, credit card receipts or balance forward statements are not acceptable. Examples of acceptable documentation include a copy of the Explanation of Benefits (EOB) from your insurance company, an itemized statement from a provider, or an itemized pharmacy receipt (if applicable to your plan).

Claim Details

Date of service	Patient's name	Relationship to employee	Name of provider	Description of service	Amount requested
				Total	$

Documentation required for recurring claims

You must include a copy of your health plan coverage letter **and** proof of your premium payment. Payment proof can be a cancelled check, credit card receipt, or bank statement.

Request for recurring claims

Payment date	Member's name	Relationship to employee/retiree	Name of carrier	Plan type	Amount requested
		☐ Self ☐ Spouse ☐ Eligible dependent		☐ Medicare Supplement ☐ Medicare Advantage ☐ Prescription Drug Plan ☐ Other health insurance	
		☐ Self ☐ Spouse ☐ Eligible dependent		☐ Medicare Supplement ☐ Medicare Advantage ☐ Prescription Drug Plan ☐ Other health insurance	
		☐ Self ☐ Spouse ☐ Eligible dependent		☐ Medicare Supplement ☐ Medicare Advantage ☐ Prescription Drug Plan ☐ Other health insurance	
		☐ Self ☐ Spouse		☐ Medicare Supplement ☐ Medicare Advantage	

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		☐ Eligible dependent		☐ Prescription Drug Plan ☐ Other health insurance	
				Total	

All recurring claims will pay at the same payment frequency. Use separate forms to set different payment schedules.

_____ One time payment _____ Monthly automatic recurring payments
(Documentation does not need to be provided for future months, unless the premium amount changes.)

_____ If monthly automatic recurring, provide final reimbursement date.
Date will default to the end of the current calendar year. You will need to submit a new claim for the new calendar year if you wish to continue reimbursements after 12/31.

Authorization and certification

Read carefully: This claim will not be processed without your signature.
I certify that these expenses have been incurred by me, my spouse or my eligible dependent. The expenses have not been reimbursed and are not reimbursable under any other plan, such as an individual policy or my spouse's or dependent's plan. I understand that any amount reimbursed may not be used to claim any federal income tax deduction or credit on my or my spouse's income tax return.

______________________________ ______________________
Signature Date

Submission instructions

For fastest results, fax to: 1-443-681-4601	Or mail to:	**Claims service center** P.O. Box 622337 Orlando, FL 32862-2337

If you have any questions, please contact **Customer service at 1-877-554-1004, option 2.**

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