FSA/HRA Reimbursement Form

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Reimbursement Accounts**
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.999.7829 (cover sheet not required)

For faster processing, enter the claim and upload required documentation using the 'Claims & Payments' tab on the member portal.

Account holder information

Company name	Last 4 of SSN or HealthEquity ID number		
Last name	First name		M.I.
Street address	City	State	ZIP
Email address (required)	Daytime phone ( )	Work phone ( )	

Reimbursement information

Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
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Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
	TOTAL AMOUNT REQUESTED	$

CERTIFICATION AND AUTHORIZATION:

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the HealthEquity's User Agreement.

Reimbursement method

☐ **Option 1—Check**
This method is slower. Please allow 7–10 business days to receive your check.

☐ **Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® FSA.**
(If an EFT is not on file, a check will be sent. Please allow 7-10 business days for the check to arrive.)

☐ **Option 3—Transfer the funds to the following account.**
(**Note**: E-mail address is required for EFT.)

Account type: ☐ Checking ☐ Savings

Financial institution:____

City/state:____

Routing number:____

Account number:____

Your Name
123 Main Street
Any Town, USA 54321
1234
98-123-1/4359
________20___
Pay to the order of ________________ $
________________ Dollars
Your Financial Institution
400 Countrywide Way
Simi Valley, Ca 93065
For______________
⑆1 2 2000 78 9⑆ 0123456789⑈ 1234
Routing Number
Account Number
Check Number (Do not include)

A copy of a voided check must be included to verify banking information otherwise a check will be sent and a $2.00 fee may apply.

Note: Please attach proper documentation to this form. An explanation of benefits or itemized receipt is required. Documentation must include the actual date(s) of service, patient name, provider's name, description of service, and the cost. If you have additional expenses, please complete an additional form. **Send only copies of receipts.** Keep original receipts for your records.

Update: Effective Jan. 1, 2011, a prescription or letter of medical necessity may be required for medicinal over-the-counter items (i.e. aspirin). A letter of medical necessity form is available on your HealthEquity® member portal.

Reimbursement requests can also be made online at www.MyHealthEquity.com.