

# HSA Reimbursement Form



Mail or fax completed forms to:

**Address:** HealthEquity, Attn: Member Services  
PO Box 14374, Lexington, KY 40512

**Fax:** 801.727.1005

Primary Account Holder Information			
Last Name	First Name	M.I.	
Street Address	City	State	ZIP
E-Mail Address (required)	Daytime Phone ( )	SSN or HealthEquity ID Number	

Reimbursement Information	
Provider Name	Date of expense
Patient Name	Total Reimbursement*
Type of expense: <input type="checkbox"/> Medical <input type="checkbox"/> Prescription <input type="checkbox"/> Dental <input type="checkbox"/> Vision ( <b>Note:</b> No documentation is needed. Keep receipts for your records.)	

\*If the requested reimbursement amount is higher than your available balance, we will only process the reimbursement up to the available balance in the account. **An account closure fee is held in reserve from your account and may not be used for reimbursement.**

Reimbursement Method	
<input type="checkbox"/> <b>Option 1—Check.</b> This method is slower. Please allow 7–10 business days to receive your check. <b>A \$2.00 fee will be deducted from your health savings account (HSA).</b>	
<input type="checkbox"/> <b>Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® HSA.</b> (If an EFT is not on file, a check will be sent and a \$2.00 fee may apply. Please allow 7-10 business days for the check to arrive.)	
<input type="checkbox"/> <b>Option 3—Transfer the funds to the following account.</b> ( <b>Note:</b> E-mail address is required for EFT.)	
Account type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	<p>Your Name 123 Main Street Any Town, USA 54321</p> <p>Pay to the order of _____ \$ _____ Dollars</p> <p>Your Financial Institution 400 Countrywide Way Simi Valley, Ca 93065</p> <p>For _____</p> <p>Routing Number: 01 2000 78 9    Account Number: 0123456789    Check Number: 1234 (Do not include)</p>
Financial institution: _____	
City/state: _____	
Routing number: _____	
Account number: _____	
<b>Form must be accompanied by a copy of a voided or actual check.</b>	

Reimbursement Authorization		
By signing below, I authorize HealthEquity to reimburse me from my health savings account (HSA) for my expense in the manner specified above and I represent that the information I provided in this request is true and complete.		
Name (please print)	Signature	Date

Reimbursement requests can also be made online at [www.healthequity.com](http://www.healthequity.com).