HealthEquity®

www.HealthEquity.com

HEALTHCARE ACCOUNT

How to File a Claim for Approval

Claim Filing Options:

- **File claim online:** Log in to your account at www.HealthEquity.com to submit your claim electronically.
- **File claim via fax or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. Fax: 877-353-9236 , US Mail: CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

Instructions to fill out this form:

- Complete ALL account holder information.
- Provide your employer name without abbreviation.
- Use your documentation to complete each section of the form, including the following:
  - Provider Name
  - Service Date(s)
  - Patient Name and Relationship to Account Holder
  - Type of Service
  - Patient Responsibility
  - Provider Signature is not required, but can replace need for other proof of service

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Tips For Claim Submission

- An eligible dependent is defined as a spouse, qualifying child, or qualifying relative.
  - A qualifying child is defined as a dependent child up to age 26 or any age if permanently disabled.
  - A qualifying relative is someone who resides with you for more than half of the year.
  - Qualifying children and relatives must not provide more than half of his/her own support.
- For a complete list of eligible expenses specific to your plan, log in to your account at www.HealthEquity.com. Only submit claims for eligible expenses.
- A letter of medical necessity is required for any expense listed as "Yes (Letter)" on the eligible expense list to establish medical necessity. Cosmetic surgery or procedures, e.g., teeth whitening, are not eligible expenses unless deemed as medically necessary by a licensed physician. A letter of medical necessity form can be obtained at: https://HealthEquity.com/account-forms.

Tip for Over-the-Counter Expenses

As of March 27, 2020, funds from your flexible spending account (FSA), health savings account (HSA) and/or health reimbursement arrangement (HRA) can be used for over-the-counter (OTC) medications and drugs. OTC medications and drugs include cold medicines, anti-inflammatories, menstrual care products and many other items. This change is retroactive to January 1, 2020 and has no expiration date. Any claims for reimbursement of OTC medicine prior to January 1, 2020 still require a prescription. FSA, HSA and HRA plans vary by employer, and these changes do not necessarily change the benefits under your employer's plan.

Tips For Documentation

- Ensure that the documentation is legible.
- Cancelled or copies of checks and credit card receipts do not contain all 6 required pieces of information needed to approve your expense, and are not acceptable for submission.
- Explanation of Benefits (EOBs) are recommended, especially if your insurance covered a portion of the expense.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- Send only photocopies of your claim form and documentation—keep the originals for your records if submitting via US Mail.
- Your provider may sign the form confirming the date of services, charges, and other service or product information in lieu of providing separate documentation or other proof of service.

Tips For Faxing

- Do not use a cover page when faxing the claim form and documentation.
- Submit only claims for your own account.

Tips for Viewing Claim Status

- Please allow 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file (to update your email address, please log in to your account at www.HealthEquity.com.

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Pay Me Back Claim Form

- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log in to your account at **www.HealthEquity.com** to file your claim electronically and upload your documentation.
- **File claim via fax or mail:** Claim forms may also be filed either via fax or US Mail and sent to the following locations: **Fax:** 877-353-9236, **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- **Claim processing time:** Claims will be processed within 2 business days after receipt of the form. You may check the status of your claim by logging in to your account at **www.HealthEquity.com**.

ACCOUNT HOLDER:

Last Name

First Name

ID Code*

Account Holder Zip Code

* ID Code is the last 4 digits of your Social Security Number, your Employee ID number or other reference number assigned by your employer. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

Employer Name

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
Signature of Provider: (Replaces the need for other proof of service.)		Patient Name: _____ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: _____ Type of Service: ☐ Rx ☐ Dental ☐ Psych/Therapy ☐ Ortho ☐ Chiro ☐ Co-payment ☐ Other _____ ☐ Lab ☐ Vision ☐ Hospital ☐ X-Ray ☐ OTC ☐ Office Visit	$
Signature of Provider: (Replaces the need for other proof of service.)		Patient Name: _____ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: _____ Type of Service: ☐ Rx ☐ Dental ☐ Psych/Therapy ☐ Ortho ☐ Chiro ☐ Co-payment ☐ Other _____ ☐ Lab ☐ Vision ☐ Hospital ☐ X-Ray ☐ OTC ☐ Office Visit	$
Signature of Provider: (Replaces the need for other proof of service.)		Patient Name: _____ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: _____ Type of Service: ☐ Rx ☐ Dental ☐ Psych/Therapy ☐ Ortho ☐ Chiro ☐ Co-payment ☐ Other _____ ☐ Lab ☐ Vision ☐ Hospital ☐ X-Ray ☐ OTC ☐ Office Visit	$
Signature of Provider: (Replaces the need for other proof of service.)		Patient Name: _____ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: _____ Type of Service: ☐ Rx ☐ Dental ☐ Psych/Therapy ☐ Ortho ☐ Chiro ☐ Co-payment ☐ Other _____ ☐ Lab ☐ Vision ☐ Hospital ☐ X-Ray ☐ OTC ☐ Office Visit	$

More expenses? Please complete another form.

CLAIM FORM TOTAL: $ 0

CERTIFICATION AND AUTHORIZATION: By submitting this form, 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 I have not/will not seek reimbursement of this expense from any other plan or party because I have already received these products and services. 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 HealthEquity website, as applicable. Use of the applicable service indicates my acceptance of the HealthEquity User Agreement at www.HealthEquity.com.