LPFSA Reimbursement Form

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Reimbursement Accounts**
PO Box 14374, Lexington, KY 40512

Fax: 801.999.7829 (cover sheet not required)

HealthEquity®

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

Account holder certification

By signing below, I request reimbursement for the qualified expenses listed above. I have attached appropriate receipts or third-party proof that I have incurred these expenses within the plan year and during the benefit period under this plan. I certify that I have not been reimbursed for these expenses from insurance or from any other source. I understand that I cannot claim these expenses on my income tax return.

Account holder signature	Date

Reimbursement method

☐ **Option 1—Check**
This method is slower. Please allow 7–10 business days to receive your check. **A $2.00 fee will be deducted from your reimbursement account.**

☐ **Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® LPFSA.**
(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.)

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

Account type: ☐ Checking ☐ Savings

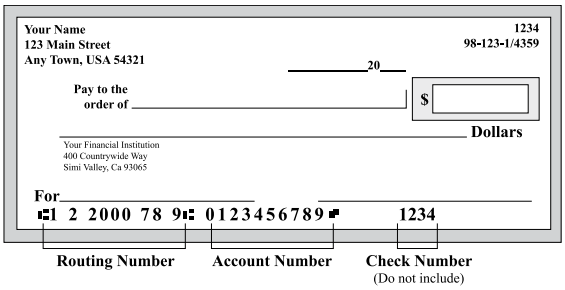
Financial institution:_____

City/state:_____

Routing number:_____

Account number:_____

Form must be accompanied by a copy of a voided or actual check.



Note: Please attach proper documentation to this form. An explanation of benefits or itemized receipt is required. Documentation must include the actual date the expense was incurred, the name of the person for who the service was provided, the provider's name, description of service, and cost. If you have additional expenses, please complete an additional form. **Send only copies of receipts.** Keep original receipts for your records. **Orthodontia contracts are required with first submission of orthodontia claims.**

Update: Effective Jan. 1, 2011, a prescription or letter of medical necessity will be required for all medicinal over-the-counter items (i.e. aspirin). Over-the-counter claims without a doctor's note will be denied. A letter of medical necessity form is available on your HealthEquity® member portal.

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