

# HSA Reimbursement Form

# HealthEquity®

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
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: ☐ Medical ☐ Prescription ☐ Dental ☐ Vision (**Note:** 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

### ☐ 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 health savings account (HSA).**

☐ Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® HSA. (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: \_\_\_\_\_

Diagram of a check showing fields for:

- Your Name: 123 Main Street, Any Town, USA 54321
- City/State/Zip: \_\_\_\_\_, \_\_\_\_\_, 1234
- Pay to the order of: \_\_\_\_\_
- Amount: \$ \_\_\_\_\_ Dollars
- Your Financial Institution: 400 Countrywide Way, Simi Valley, Ca 93065
- MICR line: ⑆ 1 2 2000 78 9 ⑆ 0123456789 ⑆ 1234
- Routing Number: 1 2 2000 78 9
- Account Number: 0123456789
- Check Number: 1234 (Do not include)

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

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