FSA/HRA Reimbursement Form

E-mail, mail, or fax completed forms to:

E-mail: reimbursementaccounts@healthequity.com

Address: **HealthEquity, Attn: Reimbursement Accounts**
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020

Fax: 801.999.7829, cover sheet not required

HealthEquity®

For faster processing, upload completed forms and documentation on your member portal.

Account Holder Information

Company Name	SSN or 6-Digit HealthEquity ID Number		
Last Name	First Name		M.I.
Street Address	City	State	ZIP
E-Mail Address (required)	Daytime Phone ( )	Work Phone ( )	

Reimbursement Information ☐ FSA ☐ HRA (required)

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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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

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.