Claims appeal form

HealthEquity®

Mail (recommended) or fax completed forms to:

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

Fax: 801.999.7829 (cover sheet not required)

Note: Do not fax this form to any other number unless instructed by HealthEquity's Member Services. Documents sent to any other number not under our instruction will be discarded for privacy/security purposes and will not be considered a properly filed appeal.

Instructions

1. HealthEquity must receive your appeal within 180 days of the date your denial notice was sent.
2. Decisions on appeals will be sent within 30 days of HealthEquity receiving the formal appeal.
3. Copies of all documents and information related to the denied claim can be provided at no charge and are also available online by accessing the denied claim from your member portal (log in at www.myhealthequity.com).
4. Appeals are reviewed by an independent person or party who was not involved in the initial claim's denial.

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 ( )	

Appeal information

Provider	Appeal submission date	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Amount requested	Excluded amount	Denial reason
Claim number	Type of account	Relationship to account holder

Explanation of appeal

Use the space provided to explain your concern. Include names, dates when possible, any supporting documentation, and your expectation or suggestions for resolution. (If more room is needed, please attach an additional page.) Attach any documentation necessary to support your claim. **Send only copies of receipts.** Keep original receipts for your records.

Account holder signature

Account holder signature	Date

If you have questions, contact the HealthEquity® Member Services team at 877.472.8632. Specialists are available every hour of every day.

SECTION TO BE COMPLETED BY HEALTHEQUITY

Did member fax or mail in supporting documentation? Check box if yes. ☐	Date	Name of reviewer

Appeal decision