Claim Filing Requirements

HealthEquity®

READ BEFORE SUBMITTING YOUR REIMBURSEMENT FORM.

DO NOT FAX THESE INSTRUCTIONS WITH YOUR REIMBURSEMENT FORM.

Required Information for Reimbursement

The IRS requires you to substantiate all claims with documentation. The documentation must detail the healthcare expenses and include 5 key data points:

- Name of provider
- Name of patient
- Description of services
- Date (s) of service. The paid date may or may not be the same as the date of service; the date of service is required. Keep copies for your tax records.
- The cost of the service

Requests submitted without the above information cannot be paid.

Credit card receipts and canceled checks are not sufficient documentation.

For faster payment, add EFT by logging in to myhealthequity.com or submitting the direct deposit form.

Claim Reimbursement Checklist

1. Complete the claim form in its entirety. Online and paper claims submissions require all necessary fields.
2. Enclose the required documentation that includes all of the data elements listed above.
3. Sign the claim form. A signature is required.
4. Keep the original receipts for your records and send copies to us.

Over-the-Counter Medications

As of January 1, 2020, you no longer need a prescription to purchase over-the-counter drugs and medicines (Advil, Ibuprofen, Aspirin, etc.).

Online Claims Submissions and Account Information

For assistance submitting claims online, to access your account, or for assistance in adding your EFT, please contact our Member Services team, available every hour of every day, at 877.472.8632 or log in to myhealthequity.com.

HRA Reimbursement Form

HealthEquity®

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

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

Account Holder Information

Company Name	Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)		
Last Name	First Name		M.I.
Street Address	City	State	ZIP
E-Mail Address (required)	Daytime Phone ( )	Work Phone ( )	

Reimbursement Information

Patient Name	Service Provider	Date Incurred (Actual date[s] of service)
Description		Amount $
Patient Name	Service Provider	Date Incurred (Actual date[s] of service)
Description		Amount $
Patient Name	Service Provider	Date Incurred (Actual date[s] of service)
Description		Amount $
Patient Name	Service Provider	Date Incurred (Actual date[s] of service)
Description		Amount $
Patient Name	Service Provider	Date Incurred (Actual date[s] of service)
Description		Amount $
Patient Name	Service Provider	Date Incurred (Actual date[s] of service)
Description		Amount $
Patient Name	Service Provider	Date Incurred (Actual date[s] of service)
Description		Amount $
	TOTAL AMOUNT REQUESTED	**$**

Start Date:____ /____ /____ End Date:____ /____ /____

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® HRA.** (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.)

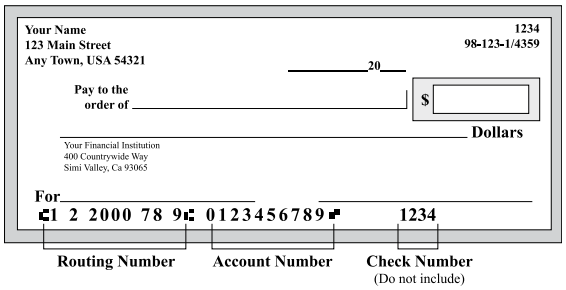
Account type: ☐ Checking ☐ Savings

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.

Update: Effective January 1, 2020, a prescription or letter of medical necessity is no longer required for medicinal over-the-counter items (i.e. aspirin).

Reimbursement requests can also be made online at myhealthequity.com.