Orthodontia Reimbursement Form

HealthEquity®

Mail or fax completed forms to:

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

Fax: 801.999.7829

For faster processing, enter the claim and upload required documentation using the 'Claims & Payments' tab on the member portal.

Account holder information ☐ Change of address

Company name		Last 4 of SSN or HealthEquity ID number	
Last name	First name		M.I.
Street address	City	State	ZIP
Mailing address (if different from street address)	City	State	ZIP
Email address (required)	Daytime phone ( )	Work phone ( )	

Orthodontia reimbursement information (Review options below)

Orthodontia contracts are required with the first submission of orthodontia claims.

Select option (Required)

☐ **Annual**: Elect this option if your orthodontia amount is the same each month. HealthEquity will send automatic payments for the remaining *plan year*. With this option, you won't need to submit a new form each month. Payments will continue unless you request they be discontinued. You will need to submit a new orthodontia reimbursement form at the beginning of the new plan year. Annual option will be paid on the last business day of the month.

☐ **Pay as-you-go**: Select this option if orthodontia amounts are different each month.

Initial orthodontic payment (Amount paid to orthodontist at initial treatment)		Date paid: ____ /____ /____	$
Date of service: _____ /_____ /_____	Service provider	Patient name	Monthly amount $
Date of service: _____ /_____ /_____	Service provider	Patient name	Monthly amount $
Date of service: _____ /_____ /_____	Service provider	Patient name	Monthly amount $
		TOTAL REQUESTED	$

Account holder certification

Certification: 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 haven't been reimbursed for these expenses by my insurance or any other source. I understand that I can't claim these expenses on my income tax return.

Account holder signature	Date

If you have additional expenses, please complete an additional form. **Send only copies of receipts.** Keep original receipts for your records.

If you have questions, contact HealthEquity® member services at 877.472.8632, they are available every hour of every day to assist you.