# Return of reimbursement account overpayment

HealthEquity®

Email, mail or fax completed forms to:

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

**Fax:** 520.844.7090 (cover sheet not required)

## Primary account holder information

| | | | |
|---|---|---|---|
| Employer name (if applicable) | | | |
| Last name | First name | | M.I. |
| Street address | City | State | ZIP |
| Email address (required) | Daytime phone ( ) | Last 4 of SSN or HealthEquity ID number | |

## Return of overpayment information

Account to apply overpayment to: ☐ FSA/LPFSA ☐ HRA ☐ DCRA ☐ HIA

| | |
|---|---|
| **Card transaction date** | **Claim number** |
| Provider/Merchant | Amount $ |
| **Card transaction date** | **Claim number** |
| Provider/Merchant | Amount $ |

## Banking information (If no option is selected, form is void)

☐ **Option 1—**Check

Include a check payable to HealthEquity with this form and mail to:
HealthEquity, Attn: Client Services, PO Box 14374, Lexington, KY 40512

**Please include "overpayment" in the memo line of your check and include which card transaction or claim number to reference payment.**

When you provide a check as payment, you authorize HealthEquity to either use the information from your check to make a one-time, Back Office Conversion (BOC), electronic fund transfer from your account if eligible, or to process the payment as a check transaction. Funds processed via BOC may be withdrawn from your account as soon as the same day your payment is received.

☐ **Option 2—**One-time electronic funds transfer (EFT)

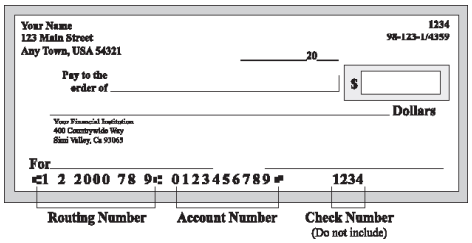
Fax this form and a copy of a voided check to:
HealthEquity, attn: Client Services, 520.844.7090.

Account type: ☐ Checking ☐ Savings Amount: $_____

Financial institution:_____

Routing number:_____ Account number:_____

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




☐ **Option 3—**Use the verified EFT account already tied to my account.

## Authorization

This form is required to correct an overpayment made for your reimbursement account. By signing below, I swear or affirm that the correction from my reimbursement account in the amount stated above is a correction of an overpayment resulting from a mistake of fact due to reasonable cause.

| Name (please print) | Signature | Date |
|---|---|---|
| | | |

