HealthEquity®

FSA/HRA Reimbursement Form

Please mail, fax or email completed forms to:
HealthEquity Claims
15 West Scenic Pointe Drive, Suite 400 Draper, UT 84020
Fax: 801-999-7829
Email: reimbursementaccounts@healthequity.com

Participant Information

☐ Change of Address

Company Name		Employee Social Security Number	
Last Name	First Name		M.I.
Street Address	City	State	Zip
Email Address	Home Phone # (Including area code) ( )	Work Phone # (Area code and extension) ( ) Ext.	

Healthcare Reimbursement

Date Incurred	Patient Name*	Service Provider	Description	Amount
____/____/____				$
____/____/____				$
____/____/____				$
____/____/____				$
Patient name is required to process RA claims and will be denied without a patient name on the supporting documents.			Total (Required)	$

Dependent Care Reimbursement

Please have your day care provider sign below in the "Provider Signature" section. If your provider does not sign in the "Provider Signature" section you must attach a bill or receipt showing **ACTUAL DATES OF SERVICE** (not the date that you paid the provider), **Cost**, and the **Care Provider's Tax ID** or **Social Security Number.**

Date Incurred	Service Provider	Tax ID or SSN	Amount
Begin Date:____/____/___ End Date: ____/____/____			$
Begin Date:____/____/___ End Date: ____/____/____			$
		Total (Required)	$

Provider Certification: That I am a qualified care provider as defined by the Internal Revenue Code, and that the expenses for services claimed below have actually been provided. **(Provider signature is only required when an itemized receipt for services is not available)**

Dependent Care Provider Signature:_____ Date:_____

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 have not been reimbursed for these expenses under our insurance or under any other source. I understand that I cannot claim these expenses on my personal tax return.

Participant 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 whom the service was provided, the provider name, description of service, and the cost.

If you have additional expenses, please complete an additional form. **Do not send original receipts.**

Update: Effective January 1, 2011 a prescription or letter of medical necessity will be required for all medicinal over-the-counter items (E.g. 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.)

If you have any questions, please call our 24/7 Member Services Team at 1-866-346-5800.