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 five key data points:

1. Name of provider
2. Name of patient
3. Description of services
4. 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.
5. The cost of the service

Requests submitted without the above information cannot be processed.

Claim reimbursement checklist:

- For faster processing, submit a claim online via the 'Claims & Payments' tab. Otherwise, complete the claim form in its entirety. Incomplete requests cannot be processed.
- Include the required documentation that includes all of the five key data requirements listed above.
- Sign the claim form.
- Keep the original receipts for your records and send copies to us.

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

Over-the-counter medications

Over-the-counter (OTC) drugs and medicines along with menstrual care products are now eligible without a written prescription as of January 1, 2020. A Letter of Medical Necessity (LMN) will still be required for vitamins and dual-purpose OTC items. The LMN is good for a 12 month period and must be dated on or before services rendered. The LMN form is available under Forms and Docs in the Member Portal. Note: OTCs purchased in 2019 will still require the written prescription and do not allow for menstrual products.

Online claims submissions and account information

For assistance submitting claims online, to access your account, or for assistance in adding your EFT, please contact HealthEquity® member services at 877.472.8632, they are available every hour of every day to assist you, or log in to www.MyHealthEquity.com.

FSA/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, enter the claim and upload required documentation using the 'Claims & Payments' tab on the member portal.

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 ( )	

Reimbursement information

Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____ /____ End date:____ /____ /____
Description		Amount $
	TOTAL AMOUNT REQUESTED	$

CERTIFICATION AND AUTHORIZATION:

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the HealthEquity's User Agreement.

Reimbursement method

☐ **Option 1—Check**
This method is slower. Please allow 7–10 business days to receive your check.

☐ **Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® FSA.**
(If an EFT is not on file, a check will be sent. 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

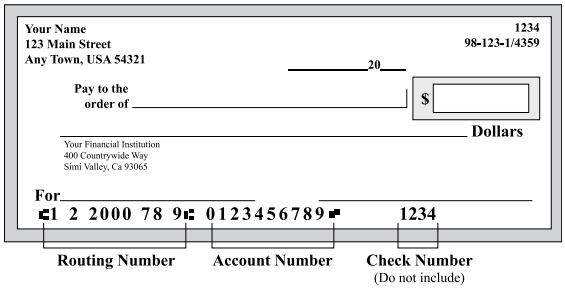
Financial institution:_____

City/state:_____

Routing number:_____

Account number:_____

A copy of a voided check must be included to verify banking information otherwise a check will be sent and a $2.00 fee may apply.



Note: Please attach proper documentation to this form. An explanation of benefits or itemized receipt is required. Documentation must include the actual date(s) of service, patient name, provider's name, description of service, and the cost. If you have additional expenses, please complete an additional form. **Send only copies of receipts.** Keep original receipts for your records.

Update: Effective Jan. 1, 2011, a letter of medical necessity may be required for medicinal over-the-counter items (i.e. aspirin). A letter of medical necessity form is available on your HealthEquity® member portal.

Reimbursement requests can also be made online at www.MyHealthEquity.com.