Claim Filing Requirements

HealthEquity®
Building Health Savings℠

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 expenses and include 5 key data points:

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

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 into www.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.

Dependent Care Accounts (DCRA)

DCRA claims can be set up on recurring payments. Please select the Annual Option on the claim form and provide an itemized receipt of the monthly amount paid, OR care provider signed claim form. A claim will be entered for the requested amount, or your election amount (whichever is greater) and payments will be sent as deposits are made into your account.

Note: A claim form signed by your care provider certifying the request replaces the need for documentation or an itemized receipt.

Online Claims Submissions and Account Information

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

Dependent Care Reimbursement Account (DCRA) Reimbursement Form

HealthEquity®
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Mail or fax completed forms to:

Address: **HealthEquity, Attn: HealthEquity Claims**
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020
Fax: 801.999.7829

Upload completed forms and documentation on your member portal for faster processing.

Account Holder Information ☐ Change of Address

Company Name		Last 4 of SSN or HealthEquity Account Number (6 or 7 digits)	
Last Name	First Name		M.I.
Street Address	City	State	ZIP
Mailing Address (if different from street address)	City	State	ZIP
E-Mail Address (required)	Daytime Phone ( )	Work Phone ( )	

Dependent Care Reimbursement Information (Review payment options below before proceeding.)

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 you paid the provider), cost, and the care provider's tax ID or Social Security number.

Select Option (Required. If an option is not selected, your request may be denied.)

☐ **Annual**: Elect this option if your dependent care amount is the same each month. HealthEquity will send automatic payments for the remaining *plan year* as deposits are posted to your account and the dates of service pass. 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 DCRA 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 you are requesting a one time reimbursement.

Date Incurred* Begin Date:_____ /_____ /_____ End Date:_____ /_____ /_____	Dependent's Name	Dependent's Date of Birth* ____ /_____ /_____	Amount* $
Service Provider	Tax ID or SSN	Reason ☐ Before/After School Program ☐ Day care ☐ Pre-K ☐ Other	
Date Incurred* Begin Date:_____ /_____ /_____ End Date:_____ /_____ /_____	Dependent's Name	Dependent's Date of Birth* ____ /_____ /_____	Amount* $
Service Provider	Tax ID or SSN	Reason ☐ Before/After School Program ☐ Day care ☐ Pre-K ☐ Other	
Date Incurred* Begin Date:_____ /_____ /_____ End Date:_____ /_____ /_____	Dependent's Name	Dependent's Date of Birth* ____ /_____ /_____	Amount* $
Service Provider	Tax ID or SSN	Reason ☐ Before/After School Program ☐ Day care ☐ Pre-K ☐ Other	
*Required fields.		**TOTAL REQUESTED**	$

Provider Certification

Provider Certification: I certify that I am a qualified care provider as defined by the Internal Revenue Code and that the expenses for services claimed above have been provided. Provider signature is only required when an itemized receipt for services isn't available.

Provider Signature	Date

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. If "No Receipt Provided" is checked, I certify that this service provider doesn't provide receipts, such as for payments made by token/ticket machine, meter, or cash box). 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

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® HRA/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

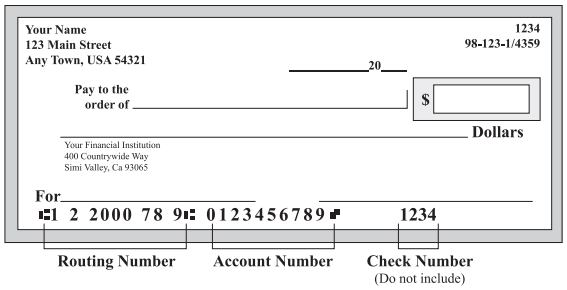
Financial institution:_____

City/state:_____

Routing number:_____

Account number:_____

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



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 the HealthEquity® Member Services at 877.472.8632, available every hour of every day.