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 healthcare expenses and include 5 key data points:

- Name of provider
- Name of patient
- Description of services
- 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. Keep copies for your tax records.
- The cost of the service

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.

Over-the-Counter Medications

Over the counter (OTC) medication is only eligible if prescribed by a medical provider to treat a specific medical condition. Please submit a written prescription or a Letter of Medical Necessity along with your request. A prescription or Letter of Medical Necessity is good for a 12 month period. The Letter of Medical Necessity form is available under Forms and Docs in the Member Portal.

Orthodontics and Dependent Care Accounts (DCRA)

Recurring payments can be scheduled for the duration of the plan year when an Orthodontia Contract is provided. If requesting an amount other than the down payment or installments, as outlined in the contract, you will need to submit an itemized payment receipt, providing the date and amount paid. DCRA claims can also 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 by your provider certifying the request by signing the 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.

Online Claims Submissions and Account Information

For assistance submitting claims online, to access your account, or for assistance in adding your EFT, please contact our 24/7 Member Services team at 877.472.8632 or login to www.myhealthequity.com.

FSA/HRA Reimbursement Form

HealthEquity®
Building Health Savings℠

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Reimbursement Accounts**
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.999.7829, cover sheet not required

For faster processing, upload completed forms and documentation on your member portal.

Account Holder Information

Company Name	Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)		
Last Name	First Name		M.I.
Street Address	City	State	ZIP
E-Mail Address (required)	Daytime Phone ( )	Work Phone ( )	

Reimbursement Information ☐ FSA ☐ HRA (required)

Patient Name	Service Provider	Date Incurred (Actual date[s] of service) Start Date:____ /____ /____ End Date:____ /____ /____
Description		Amount $
Patient Name	Service Provider	Date Incurred (Actual date[s] of service) Start Date:____ /____ /____ End Date:____ /____ /____
Description		Amount $
Patient Name	Service Provider	Date Incurred (Actual date[s] of service) Start Date:____ /____ /____ End Date:____ /____ /____
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Description		Amount $
Patient Name	Service Provider	Date Incurred (Actual date[s] of service) Start Date:____ /____ /____ End Date:____ /____ /____
Description		Amount $
	TOTAL AMOUNT REQUESTED	**$**

Account Holder Certification

By signing below, 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 from insurance or from any other source. I understand that I cannot 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. **A $2.00 fee will be deducted from your reimbursement account.**

☐ **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 and a $2.00 fee may apply. 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.)

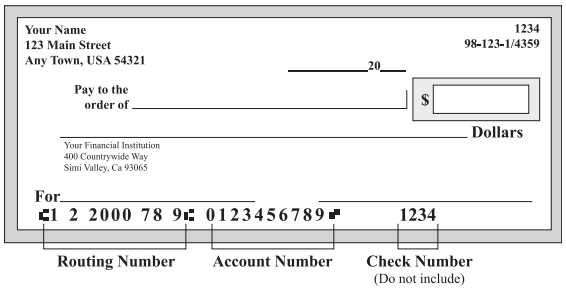
Account type: ☐ Checking ☐ Savings

Financial institution:_____

City/state:_____

Routing number:_____

Account number:_____



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

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 who the service was provided, the provider's name, description of service, and cost. If you have additional expenses, please complete an additional form. **Send only copies of receipts.** Keep original receipts for your records. **Orthodontia contracts are required with first submission of orthodontia claims.**

Update: Effective Jan. 1, 2011, a prescription or letter of medical necessity will be required for all medicinal over-the-counter items (i.e. 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.

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

Group Health Nondiscrimination Notice and Language Access Services

GROUP HEALTH NONDISCRIMINATION NOTICE

Group Health Cooperative and Group Health Options, Inc. ("Group Health") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Group Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Group Health:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact the Group Health Civil Rights Coordinator.

If you believe that Group Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Group Health Civil Rights Coordinator, Group Health Headquarters, 320 Westlake Ave. N., Suite 100, GHQ-E2N, Seattle, WA 98109, 206-448-5819, 206-877-0645 (Fax), complianceoffice@ghc.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Group Health Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 (Chinese)：注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY：1-800-833-6388 / 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY：1-800-833-6388 / 711).

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

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Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer)៖ របយ័ត៖ បើសិនអកនិយាខែរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំរេអកៗ ចូរទូ រស័ព1-888-901-4636 (TTY: 1-800-833-6388 / 711ៗ

日本語(Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-901-4636（TTY:1-800-833-6388 / 711）まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 (رقم هاتف الصم والبكم: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS : 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.