Claim filing requirements

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

Note: Credit card receipts and canceled checks are not sufficient documentation.
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 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 into www.MyHealthEquity.com or submitting the direct deposit form.
Please note: BCBSAL claims are integrated and can be viewed and paid online through your HealthEquity member portal.

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.

FSA dependent details
You are not required to add a dependent on your HealthEquity online member portal in order to be reimbursed for dependent expenses. To request a reimbursement for your eligible dependent's qualified expense, simply list each expense for the dependent (patient) on this form.

Online claims submissions and account information
Online claims submissions are not required. You can submit reimbursement requests using only this form. For assistance submitting claims online, to access your account, or for assistance in adding your EFT, please contact HealthEquity® member services at 877.288.0719, they are available every hour of every day to assist you, or login to www.MyHealthEquity.com.

FSA Reimbursement Form

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)

PEEHIP HealthEquity®

For faster processing, enter the claim and upload required documentation using the 'Claims & Payments' tab on the member portal.

Account holder information

Employer name	Last 4 of SSN or HealthEquity ID number (6 or 7 digits)		
Last name	First name		M.I.
Street address	City	State	ZIP
Email address	Home phone ( )	Cell phone ( )	

Reimbursement information (required)

Patient first name	Patient last name	Date incurred (Actual date[s] of service) Start date:____ /____ /____ End date:____ /____ /____	
Service provider	Description		Amount $
Patient first name	Patient last name	Date incurred (Actual date[s] of service) Start date:____ /____ /____ End date:____ /____ /____	
Service provider	Description		Amount $
Patient first name	Patient last name	Date incurred (Actual date[s] of service) Start date:____ /____ /____ End date:____ /____ /____	
Service provider	Description		Amount $
Patient first name	Patient last name	Date incurred (Actual date[s] of service) Start date:____ /____ /____ End date:____ /____ /____	
Service provider	Description		Amount $
Patient first name	Patient last name	Date incurred (Actual date[s] of service) Start date:____ /____ /____ End date:____ /____ /____	
Service provider	Description		Amount $
Patient first name	Patient last name	Date incurred (Actual date[s] of service) Start date:____ /____ /____ End date:____ /____ /____	
Service provider	Description		Amount $
	TOTAL AMOUNT REQUESTED	$	

Account holder certification

By signing below, I request reimbursement for the qualified expenses for myself and my eligible dependents 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.

☐ **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

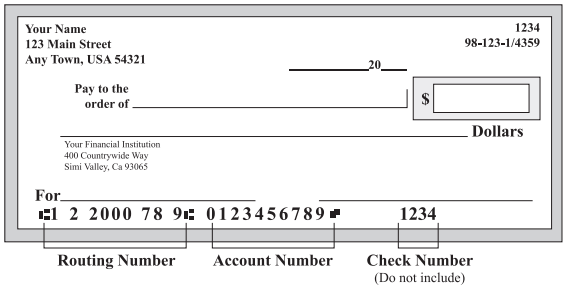
Financial institution:_____

City/state:_____

Routing number:_____

Account number:_____

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.