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 expenses and include five key data points:

1. Name of provider
2. Name of dependent receiving care
3. Description of care
4. 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.
5. The cost of the care

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.

Dependent care account (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 the care provider can sign the 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 faster processing, log in to your account at www.MyHealthEquity.com and select 'Add Claim' from the 'Claims & Payments' tab. Follow the prompts and upload your documentation to the claim. For assistance submitting claims online, accessing your account or adding an EFT, please contact member services. They are available every hour of every day at 877.288.0719 to assist you.

Dependent care reimbursement account (DCRA) reimbursement form

HealthEquity®

Mail or fax completed forms to:

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

Fax: 801.999.7829

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

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
Email 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 certification' section. If your provider does not sign in the 'Provider certification' 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 (This is 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 will not 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.

☐ **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 is not 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 does not provide receipts, such as for payments made by token/ticket machine, meter, or cash box). I certify that I have not been reimbursed for these expenses by my insurance or 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.**

☐ **Option 3—Transfer the funds to the following account.** (Email address is required for EFT)

Account type: ☐ Checking ☐ Savings

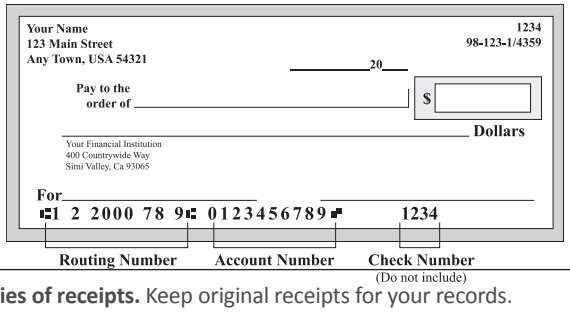
Financial institution:_____

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 HealthEquity® member services at 877.288.0719, they are available every hour of every day to assist you.