

**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](http://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 866.346.5800 or login to [www.myhealthequity.com](http://www.myhealthequity.com).

# Dependent Care Reimbursement Account (DCRA) Reimbursement Form



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.**

<b>Account Holder Information</b> <input type="checkbox"/> 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 monthly dependent care amounts are different each month.

Date Incurred* Begin Date: ___/___/___ End Date: ___/___/___	Child's Name	Child's Date of Birth ___/___/___	Amount \$
Service Provider	Tax ID or SSN	Reason <input type="checkbox"/> Before/After School Program <input type="checkbox"/> Day care <input type="checkbox"/> Pre-K <input type="checkbox"/> Other	
Date Incurred* Begin Date: ___/___/___ End Date: ___/___/___	Child's Name	Child's Date of Birth ___/___/___	Amount \$
Service Provider	Tax ID or SSN	Reason <input type="checkbox"/> Before/After School Program <input type="checkbox"/> Day care <input type="checkbox"/> Pre-K <input type="checkbox"/> Other	
Date Incurred* Begin Date: ___/___/___ End Date: ___/___/___	Child's Name	Child's Date of Birth ___/___/___	Amount \$
Service Provider	Tax ID or SSN	Reason <input type="checkbox"/> Before/After School Program <input type="checkbox"/> Day care <input type="checkbox"/> Pre-K <input type="checkbox"/> Other	
*Required fields.			<b>TOTAL REQUESTED</b> \$

## 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
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## 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
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## 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 dependent care reimbursement account (DCRA).**

**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: \_\_\_\_\_

Your Name  
123 Main Street  
Any Town, USA 54321

1234  
98-123-1/4359

\_\_\_\_\_ 20 \_\_\_\_\_

Pay to the order of \_\_\_\_\_ \$ \_\_\_\_\_ Dollars

Your Financial Institution  
400 Countrywide Way  
Simi Valley, Ca 93065

For \_\_\_\_\_

⑆ 1 2 2000 78 9⑆ 0 123456789 ⑆ 1234

Routing Number      Account Number      Check Number  
(Do not include)

**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 team at 877.472.8632. Live specialists are available 24/7/365.