

**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 877.472.8632 or login to [www.myhealthequity.com](http://www.myhealthequity.com).

# FSA/HRA 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



Building Health Savings™

**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 <input type="checkbox"/> FSA <input type="checkbox"/> 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 \$
<b>TOTAL AMOUNT REQUESTED</b>		<b>\$</b>

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: \_\_\_\_\_

Your Name 123 Main Street Any Town, USA 54321	_____ 20 _____	1234 98-123-1/4359
Pay to the order of _____	\$ _____	Dollars
Your Financial Institution 400 Countryside Way Simi Valley, Ca 93065	For _____	
<b>1 2 2000 78 9</b>	<b>0 1234 5678 9</b>	<b>1234</b>
Routing Number	Account Number	Check Number (Do not include)

**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](http://www.myhealthequity.com).**

# Kaiser Permanente Nondiscrimination Notice and Language Access Services



## KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

### **Kaiser Permanente:**

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 Kaiser Permanente Member Services.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance by phone, mail, fax, or email. If you need help filing a grievance, a Kaiser Permanente Member Services Representative is available to help you. Language assistance is provided free of charge. The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Phone: 206-630-4636

Toll-free: 1-888-901-4636

TTY Washington Relay Service: 1-800-833-6388 or 711

TTY Idaho Relay Service: 1-800-377-3529 or 711

Fax: 206-901-6205 or toll-free 1-888-874-1765

Address: Kaiser Foundation Health Plan of Washington

Civil Rights Coordinator, Quality GNE-D1E-07

P.O. Box 9812

Renton, WA 98057-9054

Email: [csforms@ghc.org](mailto:csforms@ghc.org)

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>

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

**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).

**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) :** ប្រយ័ត្ន៖ បើសិនអ្នកនិយាយខ្មែរ, សេវាជំនួយផ្នែក យេមិនគិតថ្លៃ គឺចូលរួមសេវាឥតគិតថ្លៃ។ ចូរទូរស័ព្ទ 1-888-901-4636 (TTY: 1-800-833-6388 / 711) ។

**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) :** ማሳሰቢያ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። 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).

**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।

**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: (711 / 1-800-833-6388) .

**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):** ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍ່ ວິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມ ໃຫ້ທ່ານ. ໂທ 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.