# HSA Reimbursement Form

Email, fax, or mail completed forms to:
**Email:** hsaoperations@motivhealth.com **Fax:** 844-533-1289 **Mail:** MotivHealth, Attention: HSA Operations
PO Box 709718 Sandy, UT 84070-9718

## Primary Account Holder Information

| Last Name: | First Name: | | M.I.: |
|---|---|---|---|
| Street Address: | City: | State: | ZIP: |
| Email Address (required): | Daytime Phone: | SSN or MotivHealth ID Number (6 or 7 digits): | |

## Reimbursement Information

| Provider Name: | Date of Expense: |
|---|---|
| Patient Name: | Total Reimbursement:* |

Type of expense: Medical Prescription Dental Vision **(Note: No documentation needed. Keep receipts for your records)**

*If the requested reimbursement amount is higher than your available balance, we only process the reimbursement up to the available balance in the account. **An account closure fee is held reserve from your account and may be used for reimbursement.**

## Reimbursement Method

**Option 1—Check**

This method is slower. Please allow approximately 3 weeks to receive your check.

**Option 2—Use the verified electronic funds transfer (EFT) account already tied to my MotivHealth HSA.** (If an EFT is not on file, a check will be sent. Please allow approximately 3 weeks 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.**

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⑆ 0123456789⑈ 1234
Routing Number
Account Number
Check Number (Do not include)

## Reimbursement Authorization

By signing below, you authorize MotivHealth to reimburse me from my health savings account (HSA) for my expense in the manner specified above and I represent that the information I provided in this request is true and complete.

| Name (please print): | Signature: | Date: |
|---|---|---|

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

© 2024 MotivHealth 240206