HSA Reimbursement Form

motivhealth®

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 7–10 business days 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 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

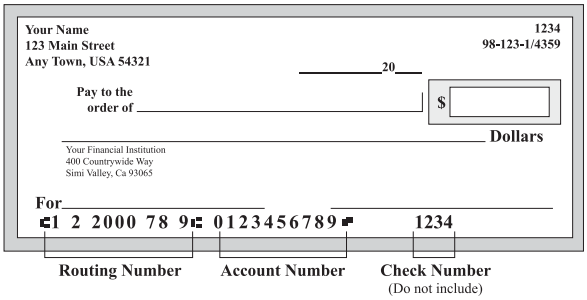
Financial institution: _____

City/state: _____

Routing number: _____

Account number: _____

Form must be accompanied by a copy of a voided or actual check.



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.