

# 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 <b>(Note: No documentation needed. Keep receipts for your records)</b>	

\*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 up to 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 up to 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: \_\_\_\_\_

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 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:
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Reimbursement requests can also be made online at [www.MotivHealth.com](http://www.MotivHealth.com).

