Orthodontia Reimbursement Form

E-mail, mail or fax completed forms to:

E-mail: reimbursementaccounts@healthequity.com
Address: **HealthEquity, Attn: HealthEquity Claims**
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020
Fax: 801.999.7829

HealthEquity®
Building Health Savings℠

Upload completed forms and documentation on your member portal for faster processing.

Account Holder Information ☐ Change of Address

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
Mailing Address (if different from street address)	City	State	ZIP
E-Mail Address (required)	Daytime Phone ( )	Work Phone ( )	

Orthodontia Reimbursement Information (Review options below)

Orthodontia contracts are required with the first submission of orthodontia claims.

Select Option (Required)

☐ **Annual**: Elect this option if your orthodontia amount is the same each month. HealthEquity will send automatic payments for the remaining *plan year*. 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 orthodontia 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 orthodontia amounts are different each month.

Initial Orthodontic Payment (Amount paid to orthodontist at initial treatment)		Date Paid:_____ /_____ /_____	$
Date of Service:_____ /_____ /_____	Service Provider	Patient Name	Monthly Amount $
Date of Service:_____ /_____ /_____	Service Provider	Patient Name	Monthly Amount $
Date of Service:_____ /_____ /_____	Service Provider	Patient Name	Monthly Amount $
		TOTAL REQUESTED	$

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. 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

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 or reimbursementaccounts@healthequity.com. Live specialists are available 24/7/365.