Claim filing requirements

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 expenses and include five key data points:

1. Name of provider
2. Name of dependent receiving care
3. Type of care
4. Date(s) of care. The paid date may or may not be the same as the date of care; the date of care is required.
5. The cost of the care

Requests submitted without the above information cannot be processed.

Claim reimbursement checklist:

- Complete the claim form in its entirety. For faster processing, submit a claim online via the 'Claims & Payments' tab.
- Include the required documentation with all of the five key data points listed above.
- Sign the claim form. A signature is required.
- Keep the original receipts for your records and send copies to us.

For faster payment, add EFT information to the reimbursement method portion of this form.

Dependent care account (DCRA)

DCRA claims can 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 the care provider can sign the claim form. A claim will be entered for your total election amount and payments will be sent out as deposits are made into your account.

Note: A claim form signed by your care provider certifying the request replaces the need for documentation or an itemized receipt.

Online claims submissions and account information

For faster processing, log in to your account at www.MyHealthEquity.com and select 'Add Claim' from the 'Claims & Payments' tab. Follow the prompts and upload your documentation to the claim. For assistance submitting claims online, accessing your account or adding an EFT, please contact member services. They are available every hour of every day at 877.472.8632 to assist you.

(DCRA) Dependent care reimbursement account reimbursement form

HealthEquity

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Claims**
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.999.7829

***Required fields**

For faster processing, enter the claim and upload required documentation using the 'Claims & Payments' tab on the member portal.

Account holder information

Company name	Last 4 of SSN or HealthEquity account number	Phone number	
Last name	First name	M.I.	
Street address	City	State	ZIP

Select option (This is required. If an option is not selected, your request may be denied.)

☐ **Annual:** Select this option if your dependent care amount will meet or exceed your elected annual amount. With this option, you will not need to submit a new form each month. HealthEquity will send automatic payments up to the election amount as deposits become available in your account. Payments will continue unless you request they be discontinued. You will need to submit a new DCRA reimbursement form at the beginning of each new plan year.

☐ **Pay as-you-go:** Select this option if you are requesting a one-time reimbursement. With this option, you will need to submit a new form for each request. If your caregiver completes and signs below, you do not need to include an itemized statement. If requesting for multiple dependents, each dependent must be listed on a separate line. Future dates of care may be scheduled out for payment.

Claim form must be filled out in its entirety. Incomplete forms may be denied.

☐ Dependents listed are under the age of 13. (If over 13 a letter of medical necessity is required to show they are mentally or physically incapable of self care.)

Date incurred*

Begin date:_____ /_____ /_______ End date:_____ /_____ /_______ ☐ Week ☐ Month ☐ Annual

Dependent's name*	Dependent's date of birth*	Service provider*	Amount*
	____ /_____ /______		$

Reason*

☐ Before/after school care ☐ Day care ☐ Pre-K ☐ Other ________________________________

Date incurred*

Begin date:_____ /_____ /_______ End date:_____ /_____ /_______ ☐ Week ☐ Month ☐ Annual

Dependent's name*	Dependent's date of birth*	Service provider*	Amount*
	____ /_____ /______		$

Reason*

☐ Before/after school care ☐ Day care ☐ Pre-K ☐ Other ________________________________

Date incurred*

Begin date:_____ /_____ /_______ End date:_____ /_____ /_______ ☐ Week ☐ Month ☐ Annual

Dependent's name*	Dependent's date of birth*	Service provider*	Amount*
	____ /_____ /______		$

Reason*

☐ Before/after school care ☐ Day care ☐ Pre-K ☐ Other ________________________________

***Required fields** ***TOTAL REQUESTED:** $

Provider certification

Please have the daycare provider sign below or attach itemized receipts.

Provider certification: I certify that I am a qualified care provider as defined by the Internal Revenue Code and that the expenses for services claimed above have been provided.

Provider signature	Date
Second provider signature (Note: This is for a second caregiver, if you have more than one.)	Date

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 have not been reimbursed for these expenses by my insurance or 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 dependent care reimbursement account (DCRA).**

☐ **Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® HRA/FSA. Select this option for faster payment or filled out the information on Option 3.**
Note: 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.** (Email address is required for EFT)

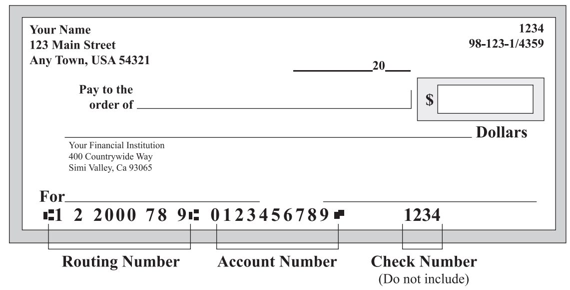
Account type: ☐ Checking ☐ Savings

Financial institution:______________________________

City/state:______________________________

Routing number:______________________________

Account number:______________________________



A copy of a voided check must be included to verify banking information otherwise a check will be sent and a $2.00 fee may apply. If you are updating EFT info once claims have been processed, you must call to update.

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 HealthEquity® member services at 877.472.8632, they are available every hour of every day to assist you.