Return of reimbursement account overpayment

HealthEquity®

Email, mail or fax completed forms to:

Address: **HealthEquity, Attn: Member Services**
15 W Scenic Pointe Dr, Draper, UT 84020

Fax: 520.844.7090 (cover sheet not required)

Primary account holder information

Employer name (if applicable)			
Last name	First name		M.I.
Street address	City	State	ZIP
Email address (required)	Daytime phone ( )	Last 4 of SSN or HealthEquity ID number	

Return of overpayment information

Account to apply overpayment to: ☐ FSA/LPFSA ☐ HRA ☐ DCRA ☐ HIA

Card transaction date	**Claim number**
Provider/Merchant	Amount $
Card transaction date	**Claim number**
Provider/Merchant	Amount $

Banking information (If no option is selected, form is void)

☐ **Option 1—**Check

Include a check payable to HealthEquity with this form and mail to:
HealthEquity, Attn: Client Services, 15 W Scenic Point Dr, Draper, UT 84020

Please include "overpayment" in the memo line of your check and include which card transaction or claim number to reference payment.

When you provide a check as payment, you authorize HealthEquity to either use the information from your check to make a one-time, Back Office Conversion (BOC), electronic fund transfer from your account if eligible, or to process the payment as a check transaction. Funds processed via BOC may be withdrawn from your account as soon as the same day your payment is received.

☐ **Option 2—**One-time electronic funds transfer (EFT)

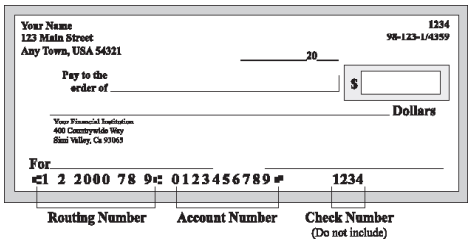
Fax this form and a copy of a voided check to:
HealthEquity, attn: Client Services, 520.844.7090.

Account type: ☐ Checking ☐ Savings Amount: $_____

Financial institution:_____

Routing number:_____ Account number:_____

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



☐ **Option 3—**Use the verified EFT account already tied to my account.

Authorization

This form is required to correct an overpayment made for your reimbursement account. By signing below, I swear or affirm that the correction from my reimbursement account in the amount stated above is a correction of an overpayment resulting from a mistake of fact due to reasonable cause.

Name (please print)	Signature	Date

