Reimbursement Request Form

Note: This form is to be completed to file a manual claim or online claim. This form should not be used to substantiate debit card expenses.

Completion Guide

Please be advised that missing information may result in the denial or delay of your request. Do not highlight documentation, as highlighted sections become unreadable in our imaging software. Documentation, as specified under "Document Requirements" must be submitted with this form.

Step 1: Your Information

***Email address*:** Include an email address if you prefer receiving notifications electronically or if your email address has changed.

Step 2: Reimbursement Information

***Plan Type*:** Enter the code (located below the claim table) to identify the account from which you are requesting reimbursement.

Did You File Online?: If a claim was filed online at myaccounts.hsabank.com, mark "Y" for yes; if not, mark "N" for no.

***Date(s) Expense(s) Incurred*:** Provide the date or range of dates the expense(s) was incurred.

***Merchant/Provider Name*:** Provide the name of the merchant or facility where the expense was incurred.

***Name of Person Receiving Product/Service*:** Provide your name or the name of the tax dependent for which the service was provided or the product was purchased.

***Claim Amount*:** Provide the total amount requested for the specified expense.

***Total Reimbursement Requested*:** Total the amounts in the "Claim Amount" boxes.

Step 2a: Dependent Care Provider Signature and Certification

Should the daycare provider be unable to provide a receipt, a signature is required in order for your Dependent Care FSA (DC-FSA) claim(s) to be paid.

Step 3: Certification

Sign and date the form after reading the certification statement.

Submit the completed form with the supporting documentation to HSA Bank:

HSA Bank, P.O. Box 2744, Fargo, ND 58108-2744 Email: hsaforms@hsabank.com Fax: 855-764-5689

Questions? Call the Client Assistance Center at 844-650-8936

Documentation Requirements

Documentation for medical expenses required by the IRS includes a third-party receipt containing the following information:

- Name of person receiving the product/service
- Merchant/provider name
- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)

Documentation for dependent care expenses required by the IRS includes a third-party receipt containing the following information:

Please be advised: If a receipt is unavailable, a signed statement from the provider that includes the below information is sufficient. Please see Step 2 of the form.)

- Name of person receiving service
- Incurred dates of service
- Dollar amount
- Name of daycare provider
- Description of services

Documentation for parking expenses include the following:

(Please be advised: if a receipt is not available, please provide a signed statement detailing expense)

- Receipt for parking

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/medical expenses where services have not yet occurred

Reimbursement Request Form

hsabank
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This form is for the reimbursement of any out-of-pocket expenses.
*Required

Step 1: Your Information

Employer Name:*	Employee ID:*
Name: (First, MI, Last)*	
Email:	Social Security Number:*

Step 2: Reimbursement Information

If you are unable to provide a receipt for any claim(s) submitted for your DC-FSA, your daycare provider must complete Step 2a. If you prefer to file only one claim for the plan year, please access the Recurring Dependent Care Request Form at myaccounts.hsabank.com.

Step 2a: Dependent Care Provider Signature and Certification (for dependent care claims)

I certify the information provided below is accurate. I understand the purpose of my signature on this form is to eliminate the necessity for the accountholder to provide receipts for reimbursement purposes.

I certify the DC-FSA information provided below is accurate.

Dependent Care Provider Signature:*

Step 2b: Claim Information

Plan Type*[1]	Did You File Online? (y/n) *	Date(s) Expense(s) Incurred*	Merchant/ Provider Name*	Description of Services (for DC-FSA and parking expenses)	Name of Person Receiving Product/ Service*	Claim Amount*
						$
						$
						$
						$
						$

[1]**Plan Types**
FSA – Limited or Healthcare Flexible Spending Account; **DC-FSA** – Dependent Care FSA;
HRA – Health Reimbursement Arrangement; **PARK** – Parking FSA; **LSA** – Lifestyle Spending Account

Total Reimbursement Requested* $ 0

Step 3: Certification

I certify that the reimbursement requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses, nor am I seeking reimbursement for these expenses from any other source. I understand that HSA Bank, its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. By submitting this request, I certify that the information provided is complete and accurate. If there are any changes in the provided information, I understand it is my responsibility to notify HSA Bank. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit. If I am requesting reimbursement for transit and parking expenses and have not provided a receipt, I certify such a receipt is not available.

Signature:*	Date:*