

## HSA Request for Reimbursement

### Account Information

Last Name	First Name	MI	Account Number:
Street	Suite or Apartment		
City	State	Zip Code	
PHONE: _____		FAX: _____	
<i>The number(s) where we may contact you during business hours</i>			
<b>Check here if this is a change of address [ ] or telephone [ ]</b>			

### Expense Reimbursement Information

Please DO NOT send your medical receipts. Retain all receipts for your personal records and tax receipts. You do not need to provide detailed information on the expenses to Health Savings Administrators. You may enter only the "Total" if you choose.

Date of Service	Description of Service	Patient's Name	Amount of Expense
<b>Total</b>			

**I certify that the above information is accurate and represents expenses that I have incurred. These expenses were incurred by me (and/or my spouse and/or eligible dependents), and were not reimbursed by any other plan. I also certify that these expenses are qualified medical expenses under Section 213(d) of the Internal Revenue Code.**

\_\_\_\_\_  
*Signature of Accountholder*

\_\_\_\_\_  
*Date Signed*

**Have your reimbursement deposited directly into your personal checking account.  
 Download and complete the [Electronic \(ACH\) Reimbursement Authorization form](#).**

Please fax or mail this form to:

**Health Savings Administrators**  
 10800 Midlothian Turnpike, Suite 240  
 Richmond, VA 23235  
 804-726-1570