

Orthodontia Reimbursement Form



Mail or fax completed forms to:

Address: HealthEquity, Attn: HealthEquity Claims
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020
Fax: 801.999.7829

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

Account holder information <input type="checkbox"/> 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
Email 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)			
<input type="checkbox"/> Annual: Elect this option if your orthodontia amount is the same each month. HealthEquity will send automatic payments for the remaining <i>plan year</i> . 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.			
<input type="checkbox"/> 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 HealthEquity® member services at 877.472.8632, they are available every hour of every day to assist you.