Repayment for Ineligible Reimbursement

Instructions — Complete all fields below and return signed form and any required documentation to:

Online: Log in to your HSA Bank account. If you haven't created your username and password yet, please do so at hsabank.com and then log in. Next, select Resources from the left navigation, and in the Secure Document Upload section, click Upload.
Email: **hsaforms@hsabank.com**; Mail: HSA Bank, P.O. Box 939, Sheboygan, WI 53082

Call 800-357-6246 for assistance.

Step 1: Accountholder information	
Employer name (If sponsored by an employer plan):	Accountholder name (First, MI, Last):
Accountholder email address:	Full Social Security number:
Step 2: Original claim or transaction information	
Name of the provider/merchant:	Transaction date:
Amount of the reimbursement:	Claim number:

Step 3: Repayment and additional documentation

I used my HSA Bank Health Benefits Debit Card to pay for an expense that was determined ineligible or I received a reimbursement from HSA Bank for an expense that was later determined to be either: ineligible, an overpayment, a duplicate reimbursement, or covered by other insurance.

☐ I have enclosed a check payable to HSA Bank to repay this reimbursement.

☐ Instead of repaying by check, I am submitting substantiation for a different, eligible claim including: patient name, date of service, type of item or service and amount, or an Explanation of Benefits (EOB) to offset the ineligible reimbursement.

Note: For an HRA expense you must submit an EOB. Your eligible expense must equal or exceed the total of your ineligible expense or your card privileges will continue to be suspended until the debt is paid in full.

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Expense was Incurred	Amount

Upon receipt these repayments will be processed against your benefit account and your account balance will be adjusted. The undersigned participant in the Plan certifies that all expenses being submitted for reimbursement on this claim form were incurred during a period when the undersigned was covered under the Company's benefit account. In addition, the undersigned certifies that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that they are fully responsible for the accuracy of all information relating to this claim and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for repayment of all such expenses.

Step 4: Authorized accountholder signature	
Signature:	**Date:**