

# Health Savings Administrators

## HSA Request for Reimbursement

### Account Information

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

### Expense Reimbursement Information

Please retain the medical expense information in 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

Please fax or mail this form to:

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