Health Savings Account (HSA) Reimbursement Request Form

Please use this form to submit requests for reimbursement. Fax the completed form to the number below or mail to: Wells Fargo Bank Health Benefit Services (HBS), P.O. Box 45600, Salt Lake City, UT 84145-0600

Contact Information

Name of Employer – If sponsored through an employer, otherwise enter "Individual"		Social Security Number	
Name (Last, First, Middle)			
Address	City	State	Zip Code
Home Phone (XXX-XXX-XXXX)	Work Phone (XXX-XXX-XXXX)	Carrier Name	

Expense Information

Amount	Amount	Amount
		Total

Account Holder Signature

I hereby request reimbursement for the expenses listed above. I understand that I am responsible for deciding whether or not the health care expenses listed above qualify for favorable tax treatment and that I should retain supporting documentation for these expenses should the IRS conduct an audit on my account. In addition, I understand that, if the reimbursements for the expenses listed above are not for qualified medical expenses, I may be subject to income tax and/or penalties.

Account Holder Signature _____ Date of Submission _____

Note: All reimbursements will be made by direct deposit or manual check according to your account set-up. Please allow four business days for processing.

Web site: www.wfhbs.com
Phone: (866) 890-8309
Fax: (888) 824-3868

CONFIDENTIAL ONCE COMPLETED AND RETURNED

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