Health Savings Accounts

Reimbursement Form

ACCOUNT HOLDER INFORMATION

Distributions from a Health Savings Account not used for the purpose of paying qualified medical expanse may be subject to IRS penalties and income tax. Please consult a tax advisor regarding your individual account and situation.

First Name ______________________ Middle Initial ______ Last Name ______________________

Birthday ______________ Home Address ______________________________

City ______________________ State ______________________ ZIP ______________

Social Security Number ______________________ HSA Number ______________________

Withdrawal Amount ______________________ Phone Number ______________________

REIMBURSEMENT INFORMATION

Choose one of the following:

☐ **Withdrawal/Distribution for reimbursement to MYSELF**
I paid for a medical expense and I'm requesting reimbursement for the expense.

- ☐ Cashier's Check
- ☐ Direct Deposit
  - *Account Number* ______________________
  - *Routing Number* ______________________

☐ **Withdrawal/Distribution for a direct payment to a PROVIDER**
Note: If the check is going to a provider, you must provide the patient(s) name and daytime phone number.

Patient Name ______________________ Provider Phone Number ______________

I certify the accuracy of the distribution reason selected above and authorize the transaction. I understand that I am responsible for any consequences resulting from this distribution, including any taxes and penalties owed.

______________________________ ______________
Account Holder Signature Date

SUBMISSION OPTIONS

FAX
701.356.6460
ATTN: HSA Department

MAIL
Choice Bank - HSA Department
4501 23rd Avenue S
Fargo, ND 58104

EMAIL
hsa@choicefinancialgroup.com
We recommend sending in a secure format.

HELPLINE 866.702.9033
EMAIL hsa@choicefinancialgroup.com
Live help available 8:00 am to 6:00 pm CST
Monday—Friday

choicefinancialgroup.com/hsa

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