

For Individuals > Health Savings Account HSA Reimbursement Form



ACCOUNT HOLDER INFORMATION

Distributions from a Health Savings Account not used for the purpose of paying qualified medical expense 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@bankwithchoice.com
We recommend sending in a secure format.

HELPLINE 866.702.9033

EMAIL hsa@bankwithchoice.com

*Live help available 8:00 am to 6:00 pm CST
Monday—Friday*

bankwithchoice.com/personal-hsa/



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