FURTHER℠
by HealthEquity

REIMBURSEMENT RETURN FORM

Account Holder Information (please print)

Last Name _____ First Name _____ Middle Initial _____

Street Address _____

City _____ State _____ Zip _____

Email address _____

Spending Account ID

S A _ _ _ _ _ _ _ _

Social Security # (if SA# is not known)

Daytime Phone

Returned Reimbursement Details

Returned Amount: $ _____

Original Payment was:

☐ Further Check or ACH:

Original Check or ACH Date: _____ Original Check or ACH Amount: _____

☐ Debit Card Purchase: Purchase Date: _____ Debit Card purchase paid from: ☐ FSA ☐ HRA ☐ HSA ☐ VEBA

Returned Payment by:

☐ Returning Further Check

☐ Returning Provider Check: Provider Name: _____ Provider Phone #: _____

☐ Personal Check # _____

☐ Use existing bank account on file at Further. Verify bank account number: _____

To add new banking information, login to the Online Member Service Center at hellofurther.com and access the "My Profile" page.

Reimbursement Return Reason

☐ Health plan adjusted the patient responsibility causing an overpayment from Further.

Dates of Service:_____

☐ Debit Card Purchase Returned

☐ Other:_____

Please attach a copy of the Explanation of Processing received with the reimbursement being returned.

Signature

To my knowledge, all information provided above is complete and accurate.

_____ _____

Account Holder Date

Questions? Call Member Services at 1-800-859-2144.

Send via secured email only:
further.documents@hellofurther.com

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866-231-0214

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