T: 602.899.9396
www.directedira.com

DIRECTED IRA
by Directed Trust Company

HSA Reimbursement Request

IMPORTANT INFORMATION

Use this form to request a reimbursement from your Directed HSA Account. The HSA reimbursement funds will be paid directly to the Account Holder of the HSA account. Payments are not paid to the Provider.

Processing Options

Select an option below. If no option is selected, Directed IRA will process your request as normal (within 3 business days). I understand that if my account does not have sufficient funds, my transaction may not be processed.

☐ Next-Day Service ($150) – Must be received by 4pm MST ☐ Same-Day Service ($250) – Must be received by 10am MST

1. Account Owner Information

First Name:_____ MI: _____ Last Name: _____

Last 4 of SSN: _____ Date of Birth: _____ Phone Number: _____

Directed IRA Account Number:_____

2. Reimbursement Information

Provider Name	Patient Name	Amount $
Provider Name	Patient Name	Amount $
Provider Name	Patient Name	Amount $
Provider Name	Patient Name	Amount $
Provider Name	Patient Name	Amount $
Provider Name	Patient Name	Amount $
Provider Name	Patient Name	Amount $
Provider Name	Patient Name	Amount $
		Total $

*If the requested reimbursement amount is higher than your available balance, we will only process the reimbursement up to the available balance in the account. **Account balance must maintain $500.00 minimum cash balance requirement.**

3. Reimbursement Instructions *Please select option A or B below:*

A. ☐ Check

Make Check Payable To: _____

Mail Check To: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Delivery: ☐ Regular Mail (7-10 business days) ☐ Priority Mail (2-3 business days) ($15.00) ☐ Overnight Mail ($35.00)

B. ☐ Electronic Funds Transfer

Bank Name: _____ Routing Number: _____

Account Holder's Name: _____ Account Number: _____

Reference Number: _____ Funding Deadline: _____

Delivery: ☐ Wire ☐ ACH Account Type: ☐ Checking ☐ Savings

*Routing Number may differ depending on selection

4. Account Owner Authorization

By signing below, I authorize Directed IRA to reimburse me from my Health Savings Account (HSA) for my expense in the manner specified above and I represent that the information I provided in this request is true and complete and that all reimbursements are for qualifying medical expenses per IRC 213(d) and IRS HSA account rules. Please note electronic signatures on this form must include the electronic signature Certification page or Certification Stamp. If one is not included, we will not accept this form.

➤ _____ _____

Account Owner Signature Date