

Account Holder Information (please print)			Spending Account ID #							
Last Name _____ First Name _____ Middle Initial _____			S	A						
Street Address _____			Social Security # (if SA# is not known)							
City _____ State _____ Zip _____			Daytime Phone							
Email address _____										

**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](http://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

**Fax to:**  
866-231-0214

**Mail to:**  
P.O. Box 64193  
St. Paul, MN 55164-0193