



REIMBURSEMENT RETURN FORM

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 Portal at carefirst.com/myaccount.

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 1-866-758-6199.

Send via secured email only:
CareFirstDocuments@hellofurther.com

Fax to:
866-231-0214

Mail to:
Further c/o CareFirst
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