REIMBURSEMENT RETURN FORM

Horizon

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:

☐ Horizon 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 Horizon Check

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

☐ Personal Check # _____

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

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

Reimbursement Return Reason

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

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 1-888-215-0025.

Send via secured email only:
HorizonMyWay.Documents@Hellofurther.com

Fax to:
866-231-0214

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