



Please complete all information below and print  
legibly to prevent delays in payment

Total # of Pages: \_\_\_\_\_

\_\_\_\_\_  
Name of Account Holder

\_\_\_\_\_  
Sterling HSA Account #:

**Please Reimburse Me at:** - Attach Receipts

Address: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_

City, State, Zip+4: \_\_\_\_\_

Fax #: \_\_\_\_\_

**Please Reimburse my Provider(s) below** – Attach EOB (Explanation of Benefit) and Provider(s)' Statement with address and account number (**Please complete Address & Acct # for Providers below**)

**Please Scan Receipts. Do Not Reimburse expenses.**

Amount	Date of Service	Provider's Name	Send Payment To: Include Acct # for Providers
<b>\$</b>	<b>Total Claim Amount</b>		

Date: \_\_\_\_\_

\_\_\_\_\_  
**Account Holder's Signature**

*List all providers on one sheet. If using additional pages, please enter the total claim amount on the first page. FAX or SEND form and backup information to:*

FAX: 1.877.517.4729 (toll free)	Mailing Address: Sterling HSA, 475 14 <sup>th</sup> Street, Suite 120, Oakland, CA 94612
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