



REQUEST FOR DISBURSEMENT

To prevent delays in payment, please complete all information below and print legibly.

Account Holder: _____	Sterling Acct # _____
Mailing Address: _____ _____	
Email Address: _____	Telephone Number: _____

Instructions for payment. Select a box below. All incoming faxes and attachments are scanned and attached to your account.

<input type="checkbox"/> Reimburse me	Total amount noted below is paid to the account holder and mailed to the address noted above.	Total # of Faxed Pages: _____
<input type="checkbox"/> Pay Provider(s)	Amounts paid directly to Provider(s) and mailed to address(es) indicated below. Indicate address where Provider payments are to be mailed. Please specify the Providers' account number for quick credit to your account. Attach all EOB (Explanation of Benefits) and statements.	
<input type="checkbox"/> Scan only	Faxed materials are scanned and archived only. No payment will be issued with this request.	

Amount	Service Date	Name of Provider	Mail Provider Payment To This Address:	Account Number for Provider
\$				
\$				
\$				
\$				
\$				
\$	TOTAL AMOUNT TO BE PAID FROM MY STERLING HSA ACCOUNT			

X Account Holder Signature	X Date
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<i>Fax to:</i> Toll Free 1-877-517-4729	or	<i>Mail to:</i> 475 - 14 TH Street, Ste.120, Oakland, CA. 94612
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