



# HEALTH SAVINGS ACCOUNT MEDICAL DISBURSEMENT FORM

**(DO NOT USE FOR HRA DISBURSEMENTS)** To prevent delays in payment, please complete all information below and print legibly.

Accountholder: \_\_\_\_\_ Sterling Account #: \_\_\_\_\_

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

Please change the address on my account to the above:  For this disbursement only  Permanently on my account

**COBRA Premium Payment** - Checking this box authorizes a one-time transaction to electronically transfer the amount of your COBRA premium from your health savings account to your COBRA account with Sterling (service only applies if COBRA is administered by Sterling).

Email Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

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

<input type="checkbox"/> <b>Reimburse Me</b>	Total amount noted below is paid to the accountholder and mailed to the address noted on the account, unless otherwise noted above.	Total # of Faxed Pages:  _____
<input type="checkbox"/> <b>Pay Providers</b>	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"/> <b>Scan Only</b>	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 # of Provider
\$				
\$				
\$				
\$				
\$				
\$	<b>TOTAL AMOUNT TO BE PAID FROM MY STERLING HSA ACCOUNT</b>			

Accountholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Mail To:** Sterling, P.O. Box 71107, Oakland, CA 94612 | **Email To:** customer.service@sterlingadministration.com | **Fax To:** 877-517-4729