

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

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"/> Reimburse Me	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"/> Pay Providers	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 # of Provider
\$				
\$				
\$				
\$				
\$				
\$	TOTAL AMOUNT TO BE PAID FROM MY STERLING HSA ACCOUNT			

Accountholder Signature: _____ Date: _____

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