FSA FEDS

Billing Contact Request Form

Contact Information

Please provide the correct contact information below.

Agency Name:	Contact Name:
Phone Number:	Fax Number:
Email Address:	
Overnight Mailing Address:	

Invoice Receipt

Please select how you want to receive invoices and include either your email or mailing address.

☐ **Email Address** ______________________________

☐ **Mailing Address** ______________________________

Payment Transmission

Choose how you want us to send a payment to you. *The Prompt Payment Act states all invoices must be paid within 30 days of receipt.*

☐ **Wire Payment** ☐ **ACH Payment** ☐ **Check**

Detail Format

Select your preferred method for receiving the detail that accompanies your invoice.

☐ **Encrypted CD** ☐ **Secure Email** ☐ **Paper**

______________________________ ______________________________

Signature
If sent via email, the "From" address will serve as the signature.

Date

Please return at your earliest convenience to:

- **Mailing Address:** FSAFEDS Program, P.O. Box 14127 Lexington, KY 40512-4127
- **Toll-free Fax:** 866-643-2245
- **Email:** FSAFEDSbilling@healthequity.com

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