



## EMPLOYEE REIMBURSEMENT CLAIM FORM

Please mail or fax completed form to:

DFB TPA Services. • PO Box 71027 • Madison Heights, MI 48071-0027 • (248) 336-0399 fax

**INSTRUCTIONS:**

- Complete this *entire* form
- Attach itemized bill and/or receipt of payment
- Attach primary carrier voucher or Explanation of Benefits (EOB)

*Failure to provide these items will result in a pended claim until missing items are received.*

|   |                          |                |
|---|--------------------------|----------------|
| <b>Employee Information</b>   |                          |                |
| Company Name  | Employee Member Number # |                |
| Last Name   | First Name               | M.I.           |
| Streets Address   | Home Phone #             |                |
| City  | State                    | Zip            |
| <b>Dependent Information (Required when submitting claims for your dependents)</b>  |                          |                |
| Last Name   | First Name               |                |
| Relationship to Employee (Circle One)   |                          |                |
| Spouse            Child            Full-time Student  |                          |                |
| <p>I request and authorize you to furnish DFB TPA Services, or its authorized representative, or to permit the representative to obtain a statement or review or make or obtain a copy, in whole or in part, of any or all information with respect to any illness or injury including but not limited to medical history, diagnosis, consultation, examination, prescriptions, treatments, operative procedures, X-rays, pathological findings or test you may have concerning me or my dependents. This information is to include alcohol abuse, substance abuse, or mental health records.</p> <p>A photocopy of this authorization shall be as valid as the original.</p> |                          |                |
| Amount Requested: \$ _____  |                          |                |
| Make Check Payable To: <input type="checkbox"/> Provider <input type="checkbox"/> Employee (must provide proof of payment)  |                          |                |
| Employee Signature  |                          | Date Submitted |