



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.

Employee Information		
Company Name	Employee Member Number #	
Last Name	First Name	M.I.
Streets Address	Home Phone #	
City	State	Zip
Dependent Information (Required when submitting claims for your dependents)		
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