



EMPLOYEE REIMBURSEMENT CLAIM FORM

Please mail or fax completed form to:

DFB TPA Services, LLC • PO Box 71027 • Madison Heights, MI 48071-0027 • (248) 588-4188 fax

INSTRUCTIONS:

- Complete this *entire* form for expenses incurred by you, your spouse, or dependent children for which you request reimbursement.
- You must fill out a separate claim form for each individual.
- Attach itemized bill(s) from provider(s).
- Attach primary carrier Explanation of Benefits (EOB) that match dates of service and amounts owed on invoices.

Failure to completely fill out this form for each individual and to provide the required 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 |

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. The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's reimbursement plan with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A photocopy of this authorization shall be as valid as the original.

HRA MEDICAL EXPENSES

| | Provider of Service (Doctor, etc.) | Person Receiving Service | Dates of Service (MO/DAY/YEAR) | Amount of Expense Claimed | Nature of Expense |
|---|---------------------------------------|--------------------------|-----------------------------------|------------------------------|-------------------|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

Amount Requested: \$ _____

Checks are made payable to the Employee when Employee submits an HRA claim.

| | |
|--------------------|----------------|
| Employee Signature | Date Submitted |
|--------------------|----------------|