



**MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)  
REIMBURSEMENT CLAIM FORM**

**1. PERSONAL DATA**                      **PLAN YEAR** \_\_\_\_\_

Company Name \_\_\_\_\_

Name \_\_\_\_\_ Home Phone # \_\_\_\_\_

Address \_\_\_\_\_  
(Street)                                      (Apt. #)                                      (City)                                      (State)                                      (Zip)

**2. UNREIMBURSED MEDICAL BENEFITS**

**Required documentation for reimbursement:**

- **Proof of payment and/or medical insurance explanation of benefits for medical services incurred.**

Date Medical Care Provided*	Name of Medical Provider	General Medical Expense Description. Include prescription for over-the-counter items.	Patient Name	Relation-ship	Amount that is your responsibility
<b>Total Medical Amount Requested</b>					_____

↑ \_\_\_\_\_ Please arrange documentation in order listed above.

**\* Claims for future services will not be accepted.**

**3. TERMS AND CONDITIONS**

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 Health FSA 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.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

**SUBMIT YOUR COMPLETED CLAIM FORM TO:**

**Fax:** 248-721-9120 or [claims@dfbtpa.com](mailto:claims@dfbtpa.com)  
Or Mail to:  
DFB TPA Services – Claims Department  
PO BOX 1435  
Troy, MI 48099