Employee HRA Reimbursement Claim Form

Please mail or fax completed form to:

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

Complete the information below for expenses incurred by you, your spouse, or dependent children for which you request reimbursement. You must provide receipts or other evidence the expenses were incurred. Be sure to provide all information requested on this form. If the form is incomplete it will be returned to you. Print or type the information requested, then sign and date the form.

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

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: $_________________________

Make Check Payable To (Place an X) _____ Employee (must provide proof of payment)

Employee Signature	Date Submitted