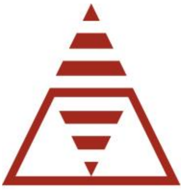

DIVERSIFIED BENEFIT SERVICES, INC.

Excellence in Benefit Management Solutions

# Health Reimbursement Arrangement (HRA) Claim Form

## Claim Filing Options

Online: File a claim online by logging into your account at www.dbsbenefits.com

Fax/Mail: Complete form below and mail or fax to: **Diversified Benefit Services, Inc.**
PO Box 260, Hartland, WI 53029
Fax (262)367-5938

**For assistance please call (800) 234-1229.**

## Participant Information

Participant Name (please print): ______________________________

Email: ______________________________ Last 4 Digits of SS#: [ ][ ][ ][ ]

Employer Name: ______________________________

Address Change (if applicable): ______________________________

Participant Signature: ______________________________ Date: ______________

## HRA Qualifying Expense Details

Who incurred the expense? (please select one of the following)

☐ Self ☐ Spouse ☐ Dependent

You must attach proper documentation to this form for reimbursement. Most plans require an Explanation of Benefits (EOB) be submitted with your claim. EOBs can be obtained from your insurance carrier or your carrier's website. If your plan does not require an EOB, documentation must include the following:

1) Date of Service
2) Patient Name
3) Provider of Service
4) Type of Service or Explanation of Service (medical, dental, vision)
5) Your Out-of-Pocket Expense (after insurance has paid, if applicable)

## Crossover to FSA

If you are currently enrolled in a Flexible Spending Account (FSA), do you want DBS to automatically apply any out-of-pocket expense to your FSA account?

☐ Yes ☐ No

**Claim Authorization** - By submitting this form, I certify that the amounts listed are correct and are expenses that represent qualified reimbursable expenses. I will not claim these items on my personal income tax return for medical itemization. I certify that I will not be reimbursed for the expenses listed above from any insurance company or insurance plan or the following: any other Flexible Benefit Plan, Medical Savings Account (MSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), another reimbursement plan or any other source. I also certify that the expenses have been incurred (having dates of service) during the timeframe required by the benefit plan and are for my own expenses, expenses of my spouse and expenses of my dependent children as defined by my employer's Plan. I will provide documentation necessary to support the amounts being requested for reimbursement. In addition, by submitting this document I acknowledge and agree DBS may, in the case of an overpayment (fraudulent, inadvertent or otherwise), offset future expense reimbursements to me to account for such an overpayment. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor to the extent that an offset of future reimbursements is either impossible or inconvenient.