**Claim Filing Options**

Online: File a claim online by logging into your account at [www.dbsbenefits.com](http://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**

Claim Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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