DIVERSIFIED
BENEFIT SERVICES

CHOICE Arrangement fka ICHRA Claim Form

For assistance please call (800) 234-1229.

Claim Filing Options

Mobile App: Download *Diversified Benefit Services* and file your claim using your username and password.
Online Account: Log into your online account at: www.dbsbenefits.com and file your claim.
Fax/Mail: Complete form below and mail or fax to: **Diversified Benefit Services, Inc.**
625 Walnut Ridge Drive, Suite 190, Hartland, WI 53029
Fax (262)367-5938

Participant Information

Participant Name (please print): _____

Email: _____ Last 4 Digits of SS#: _____

Employer Name: _____

Address Change (if applicable): _____

Participant Signature: _____ Date: _____

Individual Health Plan Premium Amount: _____

Attach a premium billing statement which includes all of the following:

1. Premium Payment Period
2. Individual Insurance Carrier Name
3. Premium Amount
4. Individual Coverage Purchased

Scheduled Premium Payment Reimbursement Plans do NOT require participant submission.

Out of Pocket Health Care: (Deductible, Copayment or Coinsurance) Amount: _____

Covered Dependent: ☐ Self ☐ Spouse ☐ Dependent
Attach a copy of the Explanation of Benefits (EOB) from your insurance carrier.

Out of Pocket Health Care (Allowed items not related to insurance plan) Amount: _____

Covered Dependent: ☐ Self ☐ Spouse ☐ Dependent
Attach a copy of an itemized receipt from the provider that includes all of the following:

1) Date of Service
2) Patient Name
3) Provider of Service
4) Type of Service or Explanation of Service (Medical supplies, RX, dental, vision, OTC)
5) Your Out-of-Pocket Expense (amounts covered by insurance excluded)

Crossover to FSA: ☐ YES Apply out of pocket expense to FSA ☐ NO Do not apply out of pocket expense to FSA

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.