DMBA

150 Social Hall Avenue, Suite 170
P.O. Box 45530 • Salt Lake City, UT 84145
Telephone: 801-578-5600 • Toll free: 800-777-3622
Fax: 801-578-5901 • Website: www.dmba.com

FLEXIBLE SPENDING CLAIM FORM FOR HEALTHCARE EXPENSES

TO AVOID DELAY, READ AND COMPLETE THE ENTIRE FORM

PERSONAL INFORMATION (REQUIRED)

Employee name: _____ DMBA ID number: _____

Employer name: _____

Employee address: _____

Home telephone: _____ Work telephone: _____

I certify these expenses are not reimbursable from any other benefit program and will not be claimed as income tax deductions. I am requesting reimbursement only for qualifying expenses incurred during the plan year for eligible participants. I authorize my Flexible Spending Account to be reduced by the amount requested.

Employee's signature: _____ **Date:** _____

Expenses incurred between January 1 and March 15 are eligible for reimbursement from either the current or the previous Flexible Spending plan year. If you are seeking reimbursement for expenses incurred within that time period, please mark one of the boxes below to indicate which plan year you would like these funds to be reimbursed from first:

❑ Previous year ❑ Current year

If you do not indicate the plan year from which you are seeking reimbursement, eligible expenses will be paid using the previous year's balance (if one exists) until it has been exhausted or until all eligible expenses have been paid.

TOTAL EXPENSES BEING CLAIMED

HEALTHCARE SERVICE: INCLUDE PATIENT'S NAME AND SERVICE DATE	TOTAL AMOUNT
	$

If you are seeking reimbursement for multiple expenses, please list the total amount being claimed in the box above. You can use the worksheet on the back of this form to itemize the expenses you are claiming.

HEALTHCARE EXPENSES DOCUMENTATION (REQUIRED)

- Attach a copy of the *Explanation of Benefits* or the denial letter from DMBA or another third-party payer. If these items are not attached, your claim will not be reimbursed until you submit proper documentation.
- If the expenses are for services excluded from your healthcare coverage (glasses, contact lenses, etc.), attach a copy of the itemized bills. You can obtain an itemized bill from the service provider. It should include the patient's name, provider's name, date services were received, total amount being claimed, and a detailed description of the product or service.
- **Balance due statements are not accepted!**
- For orthodontics, you may submit receipts from the orthodontist showing payment date, amount paid, and patient's name.

YOU MUST SUBMIT THE CORRECT INFORMATION AND SIGN THE FORM ABOVE. OTHERWISE, YOUR CLAIM WILL NOT BE PAID. ALSO, RECEIPTS SHOULD BE SUBMITTED ON A SEPARATE PIECE OF PAPER.

PLEASE SEE THE BACK OF THIS FORM

HEALTHCARE EXPENSES BEING CLAIMED

SERVICE DATE	PATIENT NAME	DESCRIPTION OF SERVICE PROVIDED	AMOUNT

GENERAL INFORMATION

- A signed *Flexible Spending Claim Form* must be submitted with each batch of requests for reimbursement.
- Expenses paid by your Flexible Spending Account(s) cannot be claimed as income tax deductions.
- When you receive your payment, you will also receive an explanation of what has been paid.
- The plan year is 14-1/2 months long, extending from January 1 through March 15 of the following year.
- Claims for the plan year must be submitted by April 30 of the following year.
- **To access your Flexible Spending Account balance, deposit history, and claims history, visit www.dmba.com.**

SUBMITTING YOUR CLAIM:

Send this claim form and any necessary attachments to:

DMBA Flexible Spending
P.O. Box 45530
Salt Lake City, Utah 84145

IF YOU HAVE ANY QUESTIONS:

Call DMBA at the appropriate telephone number or visit our website:

Salt Lake City area. 801-578-5600

Toll free 800-777-3622

Fax number 801-578-5901

Website . . . . . .www.dmba.com