Dependent Care Claim Form

(Do not fax or mail this instruction page)

Spending Account

In general, and subject to the rules of your employer's plan, the following rules apply to dependent care expenses:

- The individual receiving the care must be a child under the age of 13 or other dependents who are physically or mentally incapable of caring for themselves.
- The expenses must be incurred so that: (1) you and your spouse, if married, can work; (2) your spouse can attend school on a full-time basis; or (3) your spouse is disabled.
- Services provided by a child care or elder care center must comply with all state and local laws to be an eligible reimbursement expense.
- You can be reimbursed only for services that have been received.
- Use this form to request reimbursement of expenses incurred during the plan year
- If you are submitting expenses for more than one plan year, you can submit a separate form for each year that you are an eligible participant

Option 1: ***Go Paperless!*** You won't need to complete paper forms anymore. Just submit claims online.

Option 2: Submit your claim using this form.

Step 1: Fill out the form

- *Please print in capital letters with the letters centered in the boxes as shown:*

A	B	C	D		1	2	3	4

- *Complete a separate line for each individual expense.*
- *Use page 3 if you exceed the number of lines available on page 2.*

Step 2: Attach Supporting Documentation

- *See the "Types of Supporting Documentation" box on the right for a description of what is considered acceptable by the IRS.*
- *Do not send original receipts or supporting documentation.*
- *Photocopy your receipts or other supporting documentation onto a white, letter-sized sheet of paper.*

Step 3: Certify

- *Read the Certification and then sign and date the form.*

Step 4: Submit

- **FAX** *the form and supporting documentation to* **1.866.228.9417.**
- *Make sure that you fax the form and supporting documentation together. The form should be the first page in the stack of pages that you fax.*
- *Fax this instruction page or your own fax cover-sheet.*
- *Alternatively, you may also mail your claims to:*
  Spending Account Processing
  PO Box 25173
  Lehigh Valley, PA 18002-5173
  To expedite processing, please send only one claim and supporting documentation per envelope. Sending multiple claim forms in the same envelope may delay processing.

Remember

- *Keep a copy of the form and all original receipts for your records.*

Type of Supporting Documentation

- Copy of an itemized bill on official provider letterhead OR a bill from a babysitter. The bill must include:
  - Name/age of provider (if individual)
  - Provider's address
  - Provider's EIN (if provider facility) or Provider SSN (if individual)
  - Name/age of dependent
  - Dates of service
  - Description of change
  - Amount charged
  - Indicate care is before/after school when child is of kindergarten age or above
- In the event receipts are NOT available, please provide the Provider's signature
- Cancelled checks or payment statements are not considered acceptable evidence.

Please Do

- Include Provider's EIN (if provider facility) or SSN (if individual providing the care)
- Use additional copies of Page 3 if your expenses exceed the number of lines available on Page 2 and Page 3.
- Be sure to print legibly and use capitals.

Please Do Not

- Fill out the form using red or blue ink.
- Highlight receipts or any part of the form.
- Send original receipts.
- Staple copied receipts to the form.
- Write outside the boxes provided.
- Submit the same claim more than once.
- Fax or mail this Instructions Page.

List of Expense Codes - Sections 2 and 5 of the form need to specify the type of expense using one of the following:

Child Care	**Adult Care**
501 = Licensed Day Care	601 = Licensed Day Care
502 = Day Care	602 = Day Care
503 = Pre-School	
504 = Day Camp	

Dependent Care Claim Form

Spending Account Processing

FAX TO: 1.866.228.9417
or Mail to: Spending Account Processing Center,
PO Box 25173, Lehigh Valley, PA 18002-5173

SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS)

PARTICIPANT ID or UMI

EMPLOYER or GROUP NAME

PARTICIPANT LAST NAME

PARTICIPANT FIRST NAME

PARTICIPANT EMAIL

DAYTIME PHONE # (AREA CODE FIRST - NO DASHES)

SECTION 2: YOUR EXPENSES (Use only CAPITAL LETTERS)

EXPENSE CODE (See page 1)

PROVIDER TAX ID

STARTING DATE OF SERVICE (MMDDYY)

AMOUNT

$.

ENDING DATE OF SERVICE (MMDDYY)

DEPENDENT DATE OF BIRTH (MMDDYYYY)

EXPENSE COVERS
DEPENDENT NAME: _____

PROVIDER AFFIDAVIT: I hereby certify that the above Dependent Care charges have been incurred.
(Receipts are not required if the Dependent Care Provider signs this section.)

PROVIDER'S SIGNATURE: _____ DATE: _____

SECTION 3: SELF CERTIFICATION

I certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the program, and that these expenses have not been reimbursed or are not reimbursable under any other plan/program. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that I am solely liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original. I agree to abide by the terms of the program and have read the information on this form. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that I am solely liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original.

EMPLOYEE SIGNATURE:* _____ DATE: _____

*Your signature is required in order to process your claim for reimbursement

HDCRA

Dependent Care Claim Form

Spending Account Processing

FAX TO: 1.866.228.9417
or Mail to: Spending Account Processing Center,
PO Box 25173, Lehigh Valley, PA 18002-5173

SECTION 4: YOUR INFORMATION (Use only CAPITAL LETTERS)

PARTICIPANT ID or UMI

PARTICIPANT LAST NAME

PARTICIPANT FIRST NAME

SECTION 5: YOUR EXPENSES (Use only CAPITAL LETTERS)

EXPENSE CODE (See page 1)

PROVIDER TAX ID

STARTING DATE OF SERVICE (MMDDYY)

AMOUNT

$.

ENDING DATE OF SERVICE (MMDDYY)

DEPENDENT DATE OF BIRTH (MMDDYYYY)

EXPENSE COVERS
DEPENDENT NAME: _____

PROVIDER AFFIDAVIT: I hereby certify that the above Dependent Care charges have been incurred.
(Receipts are not required if the Dependent Care Provider signs this section.)

PROVIDER'S SIGNATURE: _____ DATE: _____

EXPENSE CODE (See page 1)

PROVIDER TAX ID

STARTING DATE OF SERVICE (MMDDYY)

AMOUNT

$.

ENDING DATE OF SERVICE (MMDDYY)

DEPENDENT DATE OF BIRTH (MMDDYYYY)

EXPENSE COVERS
DEPENDENT NAME: _____

PROVIDER AFFIDAVIT: I hereby certify that the above Dependent Care charges have been incurred.
(Receipts are not required if the Dependent Care Provider signs this section.)

PROVIDER'S SIGNATURE: _____ DATE: _____