

## EMPLOYEE INFORMATION

Employee Name: \_\_\_\_\_ Employee Address: \_\_\_\_\_  
 Company: \_\_\_\_\_  
 Last Four Digits of Social Security #: \_\_\_\_\_ Has your address changed? Yes: \_\_\_\_\_ No: \_\_\_\_\_

## DEPENDENT CARE EXPENSES

Service Start Date	Service End Date	Recurring Frequency	Service Provider Tax ID# or SS#	Service Provider Name and Address	Dependent's Name	Age	Amount
mm/dd/yyyy	mm/dd/yyyy	F Y X L M Z	N O U I M Z				
1.							
2.							
3.							

Total Dependent Care Expenses Requested

I provided the dependent care as stated above \* G B S F D V S S J O H D M B J N J T T F M F D U F E \* B U U F T U U P Q S P W

# GUIDELINES FOR CLAIMS SUBMISSION

THE INTERNAL REVENUE CODE PROVIDES THE FOLLOWING GUIDANCE

## MEDICAL REIMBURSEMENT

The best receipt is an Explanation of Benefits from your insurance company.

If other receipts are submitted, they must show the following:

- Who rendered the service (name and address).
- What type of service was rendered.
- Date Service was provided, not billing or due date.
- Amount of Charge
- Any insurance payment, if applicable.

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h # B M B P S O X F B S E D B O O P U C O M C F B J T G P F S N T B B W J P O F N B C P W T F T I P X O S F D F J Q U  
3 F D F J Q U T T I N A M T M Q F O T F T J O P W S F S E R F O S B Z N F O U G P X S J D I F F S W J D M F J T B S O P  
C F S F J N C V S T F E  
/ 0 5 & \* O P S E Q S P D F T T Z P V S D M B J O G P M S N B O C U P I O F F T B P D G S F D F J Q U  
5 I J T O D M S E F G P S T I P E P O S W D D F T

## OVER-THE-COUNTER (OTC) ITEMS

Receipts must show the following information:

- When and Who Sold the product (date, name, and address).
- Type of OTC purchased. Must show product or brand name.
- Amount of charge.

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F B D M C N J D M B I S N F T D S J C S U M P O N F F S J O B D I F B T S O P L Z Q P C J M F


## MILEAGE REIMBURSEMENT

Mileage incurred to and from your home or office to receive medical care is reimbursable through the FSA at the rate of \$ 0.1 per mile. If rate has changed, amount will be adjusted at processing. Mile claim must include substantiation. (i.e. provider invoice, receipt, ect.)

## DEPENDENT CARE REIMBURSEMENT

All receipts must show the following information:

- Who rendered the service (name and address).
- What type of service was rendered.
- Date of original service, not a billing date.
- Amount of charge.
- Federal ID number (facility) or social security number (individual)



If your daycare facility does not provide a copy of a valid receipt, then you may have the provider sign off on this claim form attesting to the validity of these charges. Canceled checks and credit card slips are not allowable receipts.

## RECURRING EXPENSE