BENEFIThelp Solutions

Dependent Care Account
Reimburse Me Claim Form

Fax: 1-888-249-5058
Submit online at www.benefithelpsolutions.com
Ph: 503-219-3679 or 1-888-398-8057
PO Box 67230 • Portland, OR 97268

DO NOT USE A FAX COVER SHEET

ACCOUNT HOLDER INFORMATION

Member ID: _____ **Phone #:** ___ - ___ - ____
Member ID or last four digits of Social Security Number (not required)

Name: _____ _____
Last First

New Address? YES

Address: _____ _____
Street Apt.

_____ ___ _____
City State Zip

Email Address: _____

Employer Name: _____ **Group #:** _____ *(if known)*

CLAIMS FOR OUT-OF-POCKET EXPENSES

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

1 _____ __/__/__ $__,___.__
Name of Dependent DOB/Age Service Start Date (MM/DD/YY) Out-of-Pocket Cost

_____ __/__/__
Name of Provider Service End Date (MM/DD/YY)

Provider's SSN or Tax ID# ___-___-____-____

Provider's Signature: _____ Date: _____
Certifies services provided. Not required. Replaces need for receipt or other proof of service.

2 _____ __/__/__ $__,___.__
Name of Dependent DOB/Age Service Start Date (MM/DD/YY) Out-of-Pocket Cost

_____ __/__/__
Name of Provider Service End Date (MM/DD/YY)

Provider's SSN or Tax ID# ___-___-____-____

Provider's Signature: _____ Date: _____
Certifies services provided. Not required. Replaces need for receipt or other proof of service.

MORE EXPENSES? Complete another form.

To submit dependent care expenses, attach documentation that includes the date(s) of service, name of provider, the tax ID# or social security number, who the care was for and the amount of the charge(s) or have your provider sign. Canceled checks, credit card receipts/statements or balance forward or balance due statements are not IRS acceptable.

$__,___.__
TOTAL THIS FORM

I request reimbursement from my Flexible Spending Account for the above listed expenses paid or to be paid by me. I certify these expenses are not covered or reimbursable from any other source, nor will I seek reimbursement for these expenses from any other source. I understand that I cannot use expenses reimbursed through the dependent care account as a tax credit when filing income tax returns. I further certify that the expenses submitted on this claim are for my qualified tax dependents as defined under Internal Revenue Code Section 152.

Account Holder Signature: _____ **Date:** _____ **Total Number of Pages:** _____
Signature of spouse or dependents is not acceptable.