



**Dependent Care FSA**  
**Reimbursement Claim Form**

To expedite your claim:

- Provide *all* appropriate information
- Review the total Expenses before printing
- Include the bar code.

**Questions? Customer Service: 800-365-9036**

Employee Name: \_\_\_\_\_

Employer Name: *(must provide this)* \_\_\_\_\_

**Dependent Child Care or Day Care Expense Claims** (*Attach supporting documentation ONLY IF the provider does not sign this form.*) Supporting documentation must include:  Provider's Name and address,  Provider's Social Security # or Tax I.D.,  Dependent's Name,  Dates of Service, and  Amount Charged. (*Credit card receipts are not acceptable.*)

Name of Dependents	Age	Date of Service		Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
		From	To		
<b>Total Dependent Care Expense Claim</b>					<b>\$</b>

\_\_\_\_\_  
Provider's Social Security # or Taxpayer ID #

\_\_\_\_\_  
Signature of Dependent Care Provider

**Read Carefully:** The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

*Please note: This bar code speeds processing of your **Dependent Care FSA** claim.*



###3T00924#####

**Fax** toll-free to **877-760-7074** (Total number of pages being sent: \_\_\_\_.)

or **E-mail** this scanned claim form and documents to [FlexClaimsAdministration@TriZetto.com](mailto:FlexClaimsAdministration@TriZetto.com)

or **Mail** this claim form and documents to:

**RightCHOICE – Flex Department, 12250 Weber Hill Road, Suite 100, St. Louis MO 63127**