



**DEPENDENT CARE REIMBURSEMENT
CLAIM FORM
(Priority Processing)**

To Be Completed By Provider

I _____ (provider) hereby certify that I have provided dependent care service to _____ (employee) for the care of his/her child(ren) for the period of _____ 20 _____ to _____ 20 _____. The amount charged was \$_____.

Provider's Signature_____

- or -

____ Attached are bills, receipts and/or statements for proof of daycare.
Canceled checks are unacceptable.

To Be Completed By Employee

Send check in the amount of \$_____

Checks cannot be issued for amounts that are greater than the current account balance, exceed the actual charges for services, or for services not yet provided. If a request is submitted for amounts greater than the account balance, the outstanding amount will be pended, and will then be paid when the account balance is again greater than the amount pended.

Please Print

Employee Name_____

ID#_____

Employer Name_____

Employee Signature_____ Date_____

Updated 11/13/2008

NOTE: All reimbursements will be paid to the employee..