Dependent care Reimbursement form

BenefitHelp SOLUTIONS

☐ **Check box if this claim is to offset a previously submitted ineligible expense.**

PLEASE PRINT CLEARLY

*** This information is mandatory.** Reimbursement may be delayed if fields with an asterisk are not filled out. Please do not use a fax cover sheet.

Section 1 Account holder information

* First name	M.I.	* Last name	* Date of birth	* SSN or BHS Identification number
			____ /____ / _____	

* Mailing address	* City	* State	* ZIP

* Email address	* Contact phone number	☐ New address

* Employer	* Group identification number (if known)

Section 2 Reimbursement request

A child care provider's signature and tax identification number will take the place of any additional substantiation. Expenses for dependents over the age of 13 are not eligible for reimbursement from your DCAP account. Please review the timelines and substantiation requirements documented in your Summary Plan Document for eligibility criteria. An expense will not be reimbursed until after the service end date.

** All expenses must be substantiated by third party documentation or completion of these boxes.

	* Name of dependent	* Date of birth (MM/DD/YY)	* Dependent's age	* Out-of-pocket cost
1		____ /____ / _____		
	* Name of provider	* Service start date (MM/DD/YY)		* Service start end (MM/DD/YY)
		____ /____ / _____		____ /____ / _____
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)
				____ /____ / _____
2	* Name of dependent	* Date of birth (MM/DD/YY)	* Dependent's age	* Out-of-pocket cost
		____ /____ / _____		
	* Name of provider	* Service start date (MM/DD/YY)		* Service start end (MM/DD/YY)
		____ /____ / _____		____ /____ / _____
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)
				____ /____ / _____

If you need more space, please use page two. Each page will contain its own total.	* Total on this form
	0.00

Section 3 Authorization

I acknowledge and certify that:

- The information submitted with this reimbursement request is accurate and complete to the best of my knowledge.
- I am requesting reimbursement for eligible expenses incurred by myself, my spouse, or my dependent while I was a participant in the plan.
- These services have already been provided or paid for.
- I have not and will not seek reimbursement for this expense from any other plan or party.
- I understand BenefitHelp Solutions reserves the right to deny a claim if I have not provided substantiation or if there is reason to believe the expense is not qualified as defined under the conditions in my Summary Plan Document or regulatory guidance.
- I agree to file IRS Form 2441 and all required identification information with my tax return.

* Employee signature	* Signature date
X	

Ready to submit? Mail, fax, email, or submit this form online to BenefitHelp Solutions.

Mail: BenefitHelp Solutions, P.O. Box 67230, Portland OR 97268

Fax: 888-249-5058 **Email:** Claims@benefithelpsolutions.com **Online:** benefithelpsolutions.com

Questions? Contact BenefitHelp Solutions at 888-398-8057.

Additional reimbursement requests

Account holder information

* First name	M.I.	* Last name	* Date of birth _____ /_____ / _____	* SSN or BHS Identification number
* Mailing address		* City	* State	* ZIP
* Email address		* Contact phone number		☐ New address
* Employer			* Group identification number (if known)	

Reimbursement request

A child care provider's signature and tax identification number will take the place of any additional substantiation. Expenses for dependents over the age of 13 are not eligible for reimbursement from your DCAP account. Please review the timelines and substantiation requirements documented in your Summary Plan Document for eligibility criteria. An expense will not be reimbursed until after the service end date.

** All expenses must be substantiated by third party documentation or completion of these boxes.

3	* Name of dependent	* Date of birth (MM/DD/YY) _____ /_____ / _____	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY) / /		* Service start end (MM/DD/YY) / /
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY) / /
4	* Name of dependent	* Date of birth (MM/DD/YY) _____ /_____ / _____	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY) / /		* Service start end (MM/DD/YY) / /
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY) / /
5	* Name of dependent	* Date of birth (MM/DD/YY) _____ /_____ / _____	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY) / /		* Service start end (MM/DD/YY) / /
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY) / /
6	* Name of dependent	* Date of birth (MM/DD/YY) _____ /_____ / _____	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY) / /		* Service start end (MM/DD/YY) / /
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY) / /
Each page will contain its own total.			* Total on this form 0	