Dependent care reimbursement form

BENEFITHelp Solutions

To help us process your reimbursement request quickly, please print clearly and return this form as instructed. Please complete all sections of this form. If your request is incomplete, has not ended or requires additional information, your reimbursement may be delayed. Please do not use a fax cover sheet.

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

Section 1 Account holder information

* First name	M.I.	* Last name	* Membership identification or SSN
* Mailing address	* City	* State	* ZIP
* Contact number	* Email address	☐ New address	
* Employer	* Group identification (if known).		

Section 2 Reimbursement request

1	* 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 end date (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 end date (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

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.

Section 3 Authorization (please read and sign below)

I acknowledge and certify that:

- The information submitted with this request is accurate and complete to the best of my knowledge.
- I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan.
- I have already received these services and confirm that by requesting reimbursement here 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.

* Employee signature	* Signature date
X	

** Reimbursement may be delayed if fields with an asterisk are not filled out.*
*** All expenses must be substantiated by third party documentation or completion of these boxes.*

Ready to submit? Mail, fax or submit this form online to BenefitHelp Solutions.
Mail: BenefitHelp Solutions, P.O. Box 67230, Portland OR 97268 Fax: 888-249-5058 Online: benefithelpsolutions.com
Questions? Contact BenefitHelp Solutions at 888-398-8057.

Additional reimbursement requests

Account holder information

* First name	M.I.	* Last name	* Membership identification or SSN
* Employer			* Group identification (if known)

Reimbursement request

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 end date (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 end date (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 end date (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 end date (MM/DD/YY)
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)
7	* 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 end date (MM/DD/YY)
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)
8	* 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 end date (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	

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.

** Reimbursement may be delayed if fields with an asterisk are not filled out.*
*** All expenses must be substantiated by third party documentation or completion of these boxes.*