

# Dependent Care Flexible Spending Account (FSA) Claim Form

(Please see instructions on reverse side)

## Employee Information (Please Print)

For address changes, please contact your employer's HR/benefits department.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Subscriber ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

## Dependent Care Flexible Spending Account

Please print — Use one line for each receipt — Don't combine two or more receipts on one line — Use additional forms if necessary.

Date of Service		Name of Dependent Receiving Service	Name of Provider of Service	Provider Tax ID No.	Requested Reimbursement Amount
From	Through				
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
<b>Total Reimbursement Requested</b>					\$

# Provider Certification

› Complete this section if dependent care receipts aren't attached.

I certify that I am a qualified caregiver as defined by the Internal Revenue Code and that the expenses for services claimed above have actually been provided.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

# Employee Information

I certify that:

- › I've received the expenses listed above and am seeking reimbursement from the Flexible Spending Account.
- › These expenses haven't been reimbursed, nor shall I seek reimbursement, from any other dependent care assistance program.
- › I haven't, and won't, claim a tax deduction credit for these expenses on my federal income tax return, nor will I claim a tax deduction or credit for these expenses on my state or local tax returns in violation of state or local law.
- › The above dependent care expenses are for the care of a Qualifying Person and do not include separate charges for food, clothing, education, entertainment, activities, late fees, or overnight care.
- › I agree to submit and keep documentation for any expenses I requested reimbursement for, as may be required by the IRS.

Please check the box below and type your first and last name and the date in the space provided:

- I acknowledge that I am signing this claim form electronically. I consent to conducting this transaction electronically, and I acknowledge that my electronic signature is the legal equivalent of my handwritten signature.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

If you don't want to submit this claim form electronically, please print, sign and return this form and supporting documentation by:

**Fax to:**  
1-888-666-1221

**Email to:**  
HDHP\_Claims@bcbst.com

**Mail to:**  
BCBST Claims Service Center  
1 Cameron Hill Circle STE 0022  
Chattanooga, TN 37402-022

**Questions:**  
Member Service  
1-800-565-9140  
bcbst.com

Please keep a copy of this form and all attachments for your records.

# Dependent Care Flexible Spending Account (FSA) Claim Reimbursement Instructions

## Certification

By signing and submitting this Dependent Care Flexible Spending Account (FSA) Claim Form, you're certifying that expenses for which you request reimbursement satisfy all the following conditions:

- › The **dependent** you're requesting reimbursement for is an eligible dependent under age 13, or meets the "Qualifying Person Test" as described in IRS Publication 503 (to view this publication go to [www.irs.gov](http://www.irs.gov)).
- › If you're claiming expenses for your **spouse**, your spouse must be physically or mentally incapable of self-care and must have the same principal residence as you for more than half the year.
- › Reimbursement can only be claimed for **services that have already been provided** regardless of when they're billed or paid.
- › **Dependent** care payments made to you, your spouse or someone you or your spouse claim as a tax dependent aren't reimbursable.
- › **Dependent** care expenses claimed were incurred so that you and/or your spouse (if married) could work or actively look for work. Your spouse is considered working (i.e., gainfully employed) if, among other requirements, they're a full-time student at an educational organization, or physically or mentally incapable of self-care.
- › **Educational expenses** incurred for a child in kindergarten and up aren't reimbursable.
- › **Tuition expenses** aren't reimbursable.
- › Expenses such as **activity fees** (e.g., field trips, swim lessons, art class), **books, supplies, transportation** and **meals** aren't reimbursable.

## Supporting Documentation

The following documentation must be provided:

- › Completed claim form, which includes the provider's signature and tax ID number
- or**
- › Itemized statement from provider which includes:
    - The provider's name.
    - Your dependent's name and relationship to you.
    - Dates services were provided.
    - The dollar amount of the services provided.

## Ineligible Documentation

Documentation that will **not** be accepted to substantiate reimbursement includes, but is not limited to:

- › Credit card receipts or cancelled checks.
- › Billing statements showing "Previous Balance," "Balance Forward," or "Received on Account."

## Before Submitting This Form Please:

- › Complete the claim form in full.
- › Sign and date the claim form.
- › If multiple items are listed on a receipt, **CIRCLE** the items filed for reimbursement. **DO NOT highlight the items.**
- › Include the appropriate documentation.
- › Make sure supporting documentation equals the total amount you're claiming for reimbursement.
- › Keep a copy of your claim form and any original receipts for your records.

