

DEPENDENT CARE PROVIDER FORM

Fax Claims to: (410) 414-8432

Email: questions@careflex.com

Phone: (888) 577-2762

CareFlex Benefit Solutions

205 West Dares Beach Road

Prince Frederick, MD 20678

Dear Dependent Care Provider:

The person named below is a participant in an employer sponsored Dependent Care Flexible Spending Account. The participant is requesting reimbursement from this pre-tax account for qualified dependent care expenses for which you have been paid or will be paid when services are rendered. In order to reimburse the participant, this form must be completed and submitted to the claims administrator, CareFlex Benefit Solutions.

PARTICIPANT INFORMATION

Employer Name:		Plan Year:	
Participant Name:			
Mailing Address:			
City:		State:	Zip:
I certify that the expenses listed have been or will be incurred for my eligible dependents during the plan year noted above and while I was a participant in the plan. I understand that I am responsible for the sufficiency, accuracy, and veracity of the information related to this expense. I have not and will not seek to be reimbursed through any other coverage for the expense listed. I further declare that I will not deduct the reimbursed expense from my federal, state or local tax returns. I have submitted this information in good faith and it is correct to the best of my knowledge. I understand that I may be liable for payment of all related taxes including federal and state income tax on amounts paid from the Plan which relate to an ineligible expense. I authorize CareFlex Benefit Solutions to obtain necessary information from providers, employer, and all other agencies or organizations to consider the claim for reimbursement under my Dependent Care Spending Account.			
Participant's Signature:		Date:	

PROVIDER INFORMATION

IRS regulations require that proof of services be provided by you, the care provider. Please use this form as a receipt to verify that the services indicated have been or will be performed at the agreed upon fee. Providers are required to complete and sign the section below.

Period Covered		Provider of Services		
From	To			
		Name:		
Name of Dependents		Address:		
		City:	State:	Zip:
		Tax ID # or SSN#:		
		Provider Phone #:	Total Expense: \$	
I hereby certify that I provided/will provide adult or child daycare services to the above individual(s) in accordance with the amounts and dates claimed above and that the information provided is accurate.				
Provider's Signature:		Date:		