ADP Benefit Services

FSADC-01

[redacted]

# Dependent Care Flexible Spending Account Claim Reimbursement Form

## How To Prepare Your Claim Form

**Step 1** Complete all employee information. This form will be processed electronically. Print clearly and only in the spaces provided.

**Step 2** Complete expense information. If the expense was incurred for an eligible dependent, indicate type of relationship in the box on the dependent name line. Use "C" for child, "S" for spouse or "O" for other.

**Step 3** Sign and date the claim form and attach bills, statements, or other proof of expenses. Your proof of expense must specify the name, tax id (or Social Security Number) of the care provider, date(s) of service, and the dependent for whom this service was provided. For your convenience, you may complete this form and obtain the signature of your provider below, in lieu of attaching receipts. Canceled checks are not sufficient evidence as proof of expense.

**IMPORTANT! DO NOT** combine multiple expenses on a single line. List each expense separately. Whether submitting single or multiple claims via fax, always send the claim form followed by its supporting documentation or receipts.

## Employee Information (PLEASE PRINT)

Please check this box if **any** of your information has changed ☐

Name

Employer Name

Address

Email Address
(By providing your email address, you will receive electronic notifications)

City

State

Zip

Daytime Phone #

Social Security Number

**Instructions**: Please use blue or black ink and print like this → 0 1 2 3 4 5 6 7 8 9

## Expense Information

| Start Date of Service | | | NOTE: Please report only one expense per block. Combining multiple expenses to one block may result in a delayed reimbursement. | | Amount | |
|---|---|---|---|---|---|---|
| MONTH | DAY | YEAR | | | DOLLARS | CENTS |
| | | | NAME OF PROVIDER | | | |
| | | | TAXPAYER ID # OR SS# OF PROVIDER | DEPENDENT D.O.B. | | |
| | | | DEPENDENT NAME | RELATIONSHIP ☐ | | |
| | | | NAME OF PROVIDER | | | |
| | | | TAXPAYER ID # OR SS# OF PROVIDER | DEPENDENT D.O.B. | | |
| | | | DEPENDENT NAME | RELATIONSHIP ☐ | | |
| | | | NAME OF PROVIDER | | | |
| | | | TAXPAYER ID # OR SS# OF PROVIDER | DEPENDENT D.O.B. | | |
| | | | DEPENDENT NAME | RELATIONSHIP ☐ | | |
| | | | NAME OF PROVIDER | | | |
| | | | TAXPAYER ID # OR SS# OF PROVIDER | DEPENDENT D.O.B. | | |
| | | | DEPENDENT NAME | RELATIONSHIP ☐ | | |

To Submit Your Claim:
Fax to: (678) 762-5900
Or Mail to: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853
Questions and Information: Call (800) 654-6695 or visit www.adpfsa.com

Total Expenses → $

## Dependent Care Provider's Signature

Check box to the right if form is signed by a dependent care provider ☐

Date

(Necessary only if receipt is not provided)

## Certification

I certify that the expenses listed above qualify for reimbursement and have been incurred by me or by eligible members of my family. These expenses have not been reimbursed by my dependent care plan or any other dependent care plan, such as my spouse's. Additionally, these expenses are not being claimed as tax deductions under Section 213 of the IRS code. Bills, statements, or other proof of the expenses are attached. If the dependent care provider box is checked, I certify that the provider did indeed sign the form validating the service being provided.

SIGNATURE

DATE