



of Tennessee
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Dependent Care Flexible Spending Account (FSA) Claim Form

- Confidential -
(Please See Instructions on Reverse Side)

Employee Information (Please Print)			
Employee Last Name	First Name	Middle Initial	BCBST Subscriber ID Number
Employee Home Address			Group Number
Employer's Name			Daytime Phone Number
Employee E-mail Address			
-- For Address Changes, Please Contact Your Employer's HR/Benefits Department --			

Dependent Care Flexible Spending Account

--- Please Print--- Use one line for each receipt --- Do not combine two or more receipts on one line --- Use additional forms if necessary ---					
Date of Service From	Through	Name of Dependent Receiving Service	Provider Name	Provider Tax ID No.	Requested Reimbursement Amount
					\$
					\$
					\$
					\$
					\$
					\$
Total Reimbursement Requested					\$

Provider Certification - Complete this section if dependent care receipts are not attached.	
Provider Name	
<i>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.</i>	
Provider Signature	Date

Employee Certification	
<p><i>I certify that:</i></p> <ul style="list-style-type: none"> • All the expenses listed above for which I am seeking reimbursement from the Flexible Spending Account have been incurred. • These expenses have not been reimbursed, nor shall I seek reimbursement, from any other dependent care assistance program. • I have not, and will not, 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 retain sufficient documentation for any expenses for which I seek reimbursement. 	
Employee Signature	Date

Return this form and supporting documentation by:	Fax To: 1-888-666-1221	Or Mail To: BCBST Claims Service Center PO Box 180150 Chattanooga, TN 37401-7150	Questions: Customer Service 1-800-565-9140 www.bcbst.com
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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 are certifying that expenses for which you request reimbursement satisfy all the following conditions:

- The **dependent** you are 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*).
- If you are 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 are billed or paid.
- **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, he or she is a full-time student at an educational organization, or physically or mentally incapable of self-care.*
- **Dependent** care payments made to you, your spouse or someone you or your spouse claim as a tax dependent are not reimbursable.
- **Educational expenses** incurred for a child in kindergarten and up are not reimbursable.
- **Tuition expenses** are not reimbursable.
- Expenses such as **activity fees** (*e.g., field trips, swim lessons, art class*), **books, supplies, transportation and meals** are not reimbursable.

SUPPORTING DOCUMENTATION - The following documentation must be provided:

- Completed claim form which includes the provider(s) 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.

UNACCEPTABLE DOCUMENTATION - Documentation that will NOT be accepted to substantiate reimbursement includes, but is not limited to:

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

BEFORE YOU SUBMIT YOUR DEPENDENT CARE REIMBURSEMENT CLAIM FORM PLEASE BE SURE TO:

- 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.
- Make sure supporting documentation equals the total amount you are claiming for reimbursement.
- Keep a copy of your claim form and any original receipts for your records.