

Flexible Spending Account/Dependent Care Account Reimbursement Instructions

Website <http://www.takecarewageworks.com>

HOW TO FILE A CLAIM FOR AN FSA or DCA EXPENSE:

File claim online: Log into your account at <http://www.takecarewageworks.com> to file your claim electronically and upload your documentation

File claim via fax: 877-782-8889

File claim via mail: Take Care by Wage Works Claims, P.O. Box 14054, Lexington, KY, 40512

File claim via e-mail: e-mail a single PDF to claims@takecareclaims.com

File claim via mobile app: sign up for free mobile access (iphone or Android)
<https://www.myflexonline.com/GoMobile.aspx>

Claim processing time: Claims will be processed within 2 business days after receipt of the form. You may check the status of your claim by logging into your account at <http://www.takecarewageworks.com>

Questions: call TakeCare by Wage Works at: (800) 950-0105

DOCUMENTATION CHECKLIST - All documentation MUST include these five key pieces of information:

1. **Provider's Name** – Facility name or person who provided the service, or if a purchase, where item was purchased (i.e. hospital, doctor, pharmacy)
2. **Service Date(s)** – Date services occurred or date item was purchased
3. **Patient's Name** - Person who received the service or whom the item is for
4. **Type of Service** – Detailed description of the service provided or item purchased
5. **Amount Billed** – The amount charged for services or product and/or the portion not reimbursed by your insurance carrier

NOTE: When filing your claim, you must attach copies of the receipts. The receipt must show the date and type of service for the expense, the provider's name, and the amount of the expense. Canceled checks, credit card slips, or statements showing only a balance due on your account are not allowable.

Flexible Spending Account – Qualified Expenses

Prescription - Qualified Expenses

Prescription and co-pays that *do* qualify for reimbursement

- Prescription medications unless they are reimbursed by insurance.
- Co-pays for prescription medications.

Prescription and co-pays that *do not* qualify for reimbursement

- Prescriptions taken strictly for cosmetic purposes and are not for reconstruction due to disease, birth defect, or accident.
- Over-the-counter drugs or medications that are not medically necessary, or are not prescribed by your physician or health practitioner.

Over-the-Counter Medicines - Qualified Expenses

Over-the-counter medicines – prescription required

- Prescriptions required for Over-the-Counter medication reimbursement.
- Some Over-the-Counter medications also require a Letter of Medical Necessity from a physician

Over-the-Counter items that DO NOT qualify for reimbursement:

- Aromatherapy
- Baby bottles and cups; Baby oil, Baby wipes
- Cosmetics
- Cotton swabs
- Dental floss; Tooth brushes
- Deodorants
- Hair regrowth
- Health Foods
- Oral care
- Shampoo and conditioner; Skin care
- Sun tanning products

Medical - Qualified Expenses

Doctor's fees and co-pays that *do* qualify for reimbursement

Co-pays and other payments to doctors and healthcare providers qualify unless they are reimbursed by insurance:

- Doctor office co-pays
- Emergency room co-pays
- Out-patient surgery co-pays
- Inpatient admission co-pays
- Office visits
- Routine check ups
- Routine physicals and other non-diagnostic services or treatments.
- Psychologist and psychiatrist fees
- Obstetrics and fertility
- Chiropractor and podiatrist fees
- Physician and Osteopath fees
- Acupuncture fees
- Christian Science practitioner's fees
- Radiology
- Surgical fees
- Lab fees
- Diagnostic fees
- X-rays and MRI
- Weight loss programs and fees pertaining to a specific disease

- Reconstructive surgery in connection with birth defects, disease, or accident.

Doctor's fees that *do not* qualify for reimbursement

- Cosmetic surgery and procedures unless it is for reconstruction due to disease, birth defect, or accident.
- Dental bleaching
- Marriage counseling
- Weight loss programs for general health or appearance.
- Over-the-counter items, drugs, or medications that are not medically necessary, or are not prescribed by your physician or health practitioner.

Health improvement programs and supplies that *do* qualify for reimbursement

Health improvement programs that qualify unless they are reimbursed by insurance:

- Physical and speech therapy
- Weight-loss programs (for specific disease)(**LOMN**)
- Quit-smoking programs
- Quit-smoking patches and gums(**Rx**)
- Alcoholism and drug treatment
- Special schooling for a disabled child(**LOMN**)
- Body scans
- Reconstructive surgery associated with birth defect, disease, or accident.
- Home drug tests
- Cholesterol tests and monitors
- Home blood tests
- Gastric bypass surgery

Health improvement programs and supplies that *do not* qualify for reimbursement

- Weight-loss programs for general health or appearance.
- Cosmetic surgery and procedures unless it is for reconstruction due to disease, birth defect, or accident.
- Dental bleaching
- Marriage counseling
- Over-the-counter items, drugs, or medications that are not medically necessary, or are not prescribed by your physician or health practitioner.

Health related expenses and equipment that *do* qualify for reimbursement

(Rx) Prescription required beginning 1/1/2011 (LOMN) Letter of Medical Necessity required from a physician

These expenses qualify *unless* they are reimbursed by insurance.

- Humidifiers and vaporizers(**LOMN**)
- First aid bandages, gloves, and masks
- Hot and cold compress packs and wraps
- Oxygen
- Pill boxes(**LOMN**)
- Shower protection for casts, prostheses, etc.
- Therapeutic support gloves(**LOMN**)
- Elevated toilet seat
- Thermometers
- Special school for disabled child(**LOMN**)
- Artificial limbs and braces
- Arches and orthopedic shoes(**LOMN**)
- Wigs for hair loss caused by disease(**LOMN**)
- Shower bars and safety handles
- Hearing devices and batteries
- Crutches and canes
- Wheelchairs, walkers, and shower chairs

- Medical alert bracelet and fees
- Bedpans and ring cushions
- Travel to doctors or healthcare facilities
- Ambulance expenses
- Breast pumps and nursing supplies

Health related expenses and equipment that *do not* qualify for reimbursement

- Expenses and equipment that are not medically necessary or are not prescribed by your health practitioner.
- Weight-loss programs for general health or appearance.

Medical Health Plan Deductible - Qualified Expenses

Deductible expenses that *do* qualify for reimbursement

- Employee responsibility for medical health plan deductible expenses, based on the explanation of benefits from your health plan.
- These may include qualified medical expenses like unreimbursed co-payments, co-insurance and doctor visits applied to your deductible amount.

Dental - Qualified Expenses

Dental services and supplies

Dental services and supplies qualify unless they are reimbursed by insurance:

- Co-payments
- Dental fillings, crowns, and bridges
- Deductibles
- Dentures
- Diagnostic fees
- Oral surgery
- Orthodontist and dentist fees
- Periodontist and endodontist fees
- Prescribed medicines
- Routine checkups
- Dental sealants
- Surgical fees
- X-rays

Dental services and supplies that *do not* qualify

- Cosmetic surgery and procedures unless it is for reconstruction due to disease, birth defect or accident.
- Dental bleaching.
- Over-the-counter items, drugs, or medications that are not medically necessary, or are not prescribed by your physician or health practitioner.

Dental Plan Deductible - Qualified Expenses

Deductible expenses that *do* qualify for reimbursement

- Employee responsibility for dental plan deductible expenses, based on the explanation of benefits from your dental plan.
- These may include qualified dental expenses like unreimbursed co-payments, co-insurance and doctor visits applied to your deductible amount.

Vision - Qualified Expenses

Vision services and supplies that *do* qualify for reimbursement

Vision services and supplies qualify unless they are reimbursed by insurance.

- Vision co-pays
- Office visits and routine eye exams
- Prescribed sunglasses and eyeglasses
- Contact lenses, solutions, and supplies

- Corrective eye surgery
- LASIK surgery
- Cataract surgery
- Optometrist fees
- Physician and ophthalmologist fees
- Surgical fees and x-rays

Vision services and supplies that *do not* qualify for reimbursement

- Cosmetic surgery and procedures unless it is for reconstruction due to disease, birth defect, or accident.
- Over-the-counter items, drugs, or medications that are not medically necessary, or are not prescribed by your physician or health practitioner.

Vision Plan Deductible - Qualified Expenses

Deductible expenses that *do* qualify for reimbursement

- Employee responsibility for vision plan deductible expenses, based on the explanation of benefits from your vision plan.
- These may include qualified vision expenses like unreimbursed co-payments, co-insurance and doctor visits applied to your deductible amount.

Claim Filing Options:

- **File claim online:** Log in to your account at takecarewageworks.com to submit your claim electronically.
- **File claim via fax, email, or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. Fax: 877-782-8889, US Mail: CLAIMS ADMINISTRATOR, PO Box 14054, Lexington, KY, 40512, Email: claims@takecareclaims.com

Instructions to fill out this form:

- Complete ALL account holder information.
- Provide your employer name without abbreviation.
- Use your documentation to complete each section of the form, including the following:
 - 1 Provider Name
 - 2 Service Date(s)
 - 3 Patient Name and Relationship to Account Holder
 - 4 Type of Service
 - 5 Patient Responsibility
 - 6 Provider Signature is *not required*, but can replace need for other proof of service

ACCOUNT HOLDER:		PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE		OUT-OF-POCKET COST
Last Name: SMITH		First Name: JOHN		
Employer Name: JONES GRAPHICS		Last 4 of SSN: 5421		Zip Code: 10063
1 PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YYYY)	3 Patient Name: <u>John Smith</u>		5 \$ 2500
Mercy Hospital	010515 010515	Relationship to Account Holder: 4 <input checked="" type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other: _____ Type of Service: <input type="radio"/> Rx <input type="radio"/> Dental <input type="radio"/> Med Deductible <input type="radio"/> Medical Fee <input type="radio"/> Coinsurance <input type="radio"/> Other: _____ <input type="radio"/> Co-payment <input type="radio"/> Vision <input type="radio"/> OTC <input type="radio"/> Office Visit		
Signature of Provider: (Replaces the need for other proof of service.) <i>Dr. Mark Johnson, M.D.</i>		Patient Name: <u>Mary Smith</u>		\$ 1070
Signature of Provider: (Replaces the need for other proof of service.)		Relationship to Account Holder: <input type="radio"/> Self <input checked="" type="radio"/> Spouse <input type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other: _____ Type of Service: <input checked="" type="radio"/> Rx <input type="radio"/> Dental <input type="radio"/> Med Deductible <input type="radio"/> Medical Fee <input type="radio"/> Coinsurance <input type="radio"/> Other: _____ <input type="radio"/> Co-payment <input type="radio"/> Vision <input type="radio"/> OTC <input type="radio"/> Office Visit		

Tips For Claim Submission

- An eligible dependent is defined as a spouse, qualifying child, or qualifying relative.
 - A qualifying child is defined as a tax dependent child up to age 26 or any age if permanently disabled.
 - A qualifying relative is someone who resides with you for more than half of the year.
 - Qualifying children and relatives must not provide more than half of his/her own support.
- For a complete list of eligible expenses specific to your plan, log in to your account at takecareWageWorks.com and select "Eligible Expense" from the left side of the screen. Only submit claims for eligible expenses.
- A letter of medical necessity is required for any expense listed as "Yes (Letter)" on the eligible expense list to establish medical necessity. Cosmetic surgery or procedures, e.g., teeth whitening, are not eligible expenses unless deemed as medically necessary by a licensed physician. A letter of medical necessity form can be obtained at: http://www.takecareWageWorks.com/ee/ee_fac.html.

Tip for Over-the-Counter Expenses

- A prescription is required for any over-the-counter expense listed as "Yes (Rx)" on the eligible expense list. As a result of the Health Care Reform Law, in addition to the required detailed receipt, an actual prescription written by a doctor (on a prescription pad or form) dated on or before the date the expense was incurred is required to verify that the over-the-counter medicine is prescribed for a known medical condition.

Tips For Documentation

- Ensure that the documentation is legible.
- Cancelled or copies of checks and credit card receipts do not contain all 6 required pieces of information needed to approve your expense, and are not acceptable for submission.
- Explanation of Benefits (EOBs) are recommended, especially if your insurance covered a portion of the expense.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- Send only photocopies of your claim form and documentation—keep the originals for your records if submitting via US Mail.
- Your provider may sign the form confirming the date of services, charges, and other service or product information in lieu of providing separate documentation or other proof of service.

Tips For Faxing

- Do not use a cover page when faxing the claim form and documentation.
- Submit only claims for your own account.

Tips for Viewing Claim Status

- Please allow 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file (to update your email address, please log into your account at takecareWageWorks.com and select "Profile" in the upper right corner of the screen).

- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log in to your account at takecareWageWorks.com to file your claim electronically and upload your documentation.
- **File claim via fax, email, or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. **Fax:** 877-782-8889, **US Mail:** CLAIMS ADMINISTRATOR, PO Box 14054, Lexington, KY, 40512, **Email:** claims@takecareclaims.com
- **Claim processing time:** Claims will be processed within 2 business days after WageWorks receives the form. You may check the status of your claim by logging in to your account at takecareWageWorks.com.

ACCOUNT HOLDER:

Last Name	First Name
Employer Name	
Last 4 of SSN	Zip Code

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER, AND TYPE OF SERVICE	OUT-OF-POCKET COST
Signature of Provider: (Replaces the need for other proof of service.)		Patient Name: _____ Relationship to Account Holder: <input type="radio"/> Self <input type="radio"/> Rx <input type="radio"/> Co-payment <input type="radio"/> Spouse <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> Qualifying Child <input type="radio"/> Med Deductible <input type="radio"/> OTC <input type="radio"/> Qualifying Relative <input type="radio"/> Medical Fee <input type="radio"/> Office Visit <input type="radio"/> Other: _____ <input type="radio"/> Coinsurance <input type="radio"/> Other _____	\$ _____
Signature of Provider: (Replaces the need for other proof of service.)		Patient Name: _____ Relationship to Account Holder: <input type="radio"/> Self <input type="radio"/> Rx <input type="radio"/> Co-payment <input type="radio"/> Spouse <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> Qualifying Child <input type="radio"/> Med Deductible <input type="radio"/> OTC <input type="radio"/> Qualifying Relative <input type="radio"/> Medical Fee <input type="radio"/> Office Visit <input type="radio"/> Other: _____ <input type="radio"/> Coinsurance <input type="radio"/> Other _____	\$ _____
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Signature of Provider: (Replaces the need for other proof of service.)		Patient Name: _____ Relationship to Account Holder: <input type="radio"/> Self <input type="radio"/> Rx <input type="radio"/> Co-payment <input type="radio"/> Spouse <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> Qualifying Child <input type="radio"/> Med Deductible <input type="radio"/> OTC <input type="radio"/> Qualifying Relative <input type="radio"/> Medical Fee <input type="radio"/> Office Visit <input type="radio"/> Other: _____ <input type="radio"/> Coinsurance <input type="radio"/> Other _____	\$ _____
CLAIM FORM TOTAL:			\$ _____

More expenses? Please complete another form.

CERTIFICATION AND AUTHORIZATION: I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) If the expense(s) claimed is covered under my Employer's Health Reimbursement Arrangement, I certify that the patient for each claim being submitted is covered under an Affordable Care Act compliant employer-sponsored group medical plan (their own, mine, or my spouse's). I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated on the WageWorks website. Use of this service indicates my acceptance of the WageWorks User Agreement at takecareWageWorks.com (available upon log in; enter User Name and Password or click on New User Registration)

Claim Filing Options:

- **File claim online:** Log into your account at takecarewageworks.com to submit your claim electronically.
- **File claim via fax, email, or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. Fax: 877-782-8889, US Mail: CLAIMS ADMINISTRATOR, PO Box 14054, Lexington, KY, 40512, Email: claims@takecareclaims.com

Instructions to fill out this form:

- ▶ Complete ALL account holder information.
- ▶ Please give your employer name without abbreviation.
- ▶ Use your documentation to complete each section of the form, including the following items:
 - 1 Provider Name
 - 2 Service Date(s)
 - 3 Dependent Name and Relationship to Account Holder
 - 4 Type of Service
 - 5 Amount Billed
 - 6 Provider Signature is *not required*, but can replace need for other proof of service.

ACCOUNT HOLDER:					
SMITH		JOHN			
Last Name		First Name			
JONES GRAPHICS					
Employer Name					
5421		10063			
Last 4 of SSN		Zip Code			
PROV NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	DEPENDENT NAME AND TYPE OF SERVICE	RELATIONSHIP TO ACCOUNT HOLDER	OUT-OF-POCKET	
Sunshine Day School	010312 010712	Dependent Name: Susan Smith Relationship to Account Holder: <input type="radio"/> Spouse <input checked="" type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other: _____	Type of Service: <input type="radio"/> Child Care <input checked="" type="radio"/> Preschool <input type="radio"/> Before/After School <input type="radio"/> Senior Day Care <input type="radio"/> Au pair <input type="radio"/> Summer Day Camp	\$ 115.00	
Signature of Provider: (Replaces the need for other proof of service.) Martha Sunshine					
Debbie's Daycare	010312 010712	Dependent Name: Jacob Smith Relationship to Account Holder: <input type="radio"/> Spouse <input checked="" type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other: _____	Type of Service: <input type="radio"/> Child Care <input checked="" type="radio"/> Preschool <input type="radio"/> Before/After School <input type="radio"/> Senior Day Care <input type="radio"/> Au pair <input type="radio"/> Summer Day Camp	\$ 130.00	
Signature of Provider: (Replaces the need for other proof of service.) Debbie Johnson					

Tips For Claim Submission

- Dependent care expenses cannot be paid to anyone who is your child or stepchild under the age of 19 and claimed as a dependent on your tax returns.
- A dependent is defined as someone who spends at least 8 hours a day in your home and is one of the following:
 - A tax dependent child under the age of 13 for whom you have custody more than half of the year.
 - A dependent that is physically or mentally incapable of self care regardless of age.
- Only submit claims for eligible expenses. Extended overnight camps, kindergarten or higher-grade tuition, non work related day care or long term care services are not eligible expenses. The only expenses considered eligible are those that are incurred while you or your spouse are working, looking for work or attending school full time.

Tips For Documentation

- Ensure that the documentation is legible.
- Cancelled or copies of checks and credit card receipts do not contain all 5 required pieces of information needed to approve your expense, and are not acceptable for submission.
- If multiple pieces of documentation are attached, please circle the dollar amount that is being claimed on each piece of documentation.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- At the end of the tax year, you are required to provide the IRS with the provider name, address and Tax ID # on Tax Form 2441 in order to obtain the tax advantage for these expenses.

Tips For Faxing

- Do not use a cover page when faxing the claim form and documentation.
- Please allow 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file (to update your email address, please log into your account at takecareWageWorks.com and select "Profile" in the upper right corner of the screen).
- Send only photocopies of your claim form and documentation – keep the originals for your records if submitting via postal mail.
- Submit only claims for your own account.

DEPENDENT CARE Pay Me Back Claim Form

- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log into your account at takecareWageWorks.com to file your claim electronically and upload your documentation.
- **File claim via fax, mail, or email:** Claim forms may also be filed either via fax or US Mail and sent to the following locations:
Fax: 877-782-8889, US Mail: CLAIMS ADMINISTRATOR, PO Box 14054, Lexington, KY, 40512,
Email: claims@takecareclaims.com
- **Claim processing time:** Claims will be processed within 2 business days after WageWorks receives the form. You may check the status of your claim by logging into your account at takecareWageWorks.com.

ACCOUNT HOLDER:

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Last Name

First Name

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Employer Name

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Last 4 of SSN

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Zip Code

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	DEPENDENT NAME, RELATIONSHIP TO ACCOUNT HOLDER, AND TYPE OF SERVICE	OUT-OF-POCKET COST														
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Signature of Provider: (Replaces the need for other proof of service.) _____																	

More expenses? Please complete another form.

CLAIM FORM TOTAL: \$

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CERTIFICATION AND AUTHORIZATION: I certify that the information on this page is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by an eligible dependent (for a child under the age of 13 or other dependents that are physically and mentally incapable of taking care of themselves) while I was a participant in the plan. These services have already been provided and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. Use of this service indicates my acceptance of the WageWorks User Agreement at takecareWageWorks.com (available upon registration; enter User Name and password or click on First Time User? link).