of Tennessee

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 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 Certification

I certify that:

- *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.*

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

☐ *I acknowledge that, by typing my name and the date below, 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 do not 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	**Or Mail To:** BCBST Claims Service Center 1 Cameron Hill Circle STE 0022 Chattanooga, TN 37402-0022	**Questions:** Customer Service 1-800-565-9140 *www.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 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 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.

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.