

# Dependent Care Claim Submission / Withdrawal Request Form

MAIL CLAIM FORM TO:

**UnitedHealthcare**  
 PO Box 1747  
 Brookfield, WI 53008-1747  
 Fax: 1-800-760-3727  
 Customer Service 1-877-797-7475

**Complete Part 1** entirely and legibly.  
**Complete Part 2** Enter Dependent Care expenses  
**Complete Part 3** Provider Name, Tax ID number  
 and Signature

Mail (or fax) the form and required documentation to the address (or fax number) provided on this form. All reimbursement requests for a plan year must be postmarked prior to the filing deadline, which is specified in your plan documents. Please refer to your plan document for health-related services that may not be covered under your specific FSA plan. For more coverage information, please refer to IRS publication 502, section 213 available at [www.irs.gov](http://www.irs.gov) or by phone at **800-TAX-FORM**. A general list of eligible/non-eligible items along with frequently asked questions are available online at [uhcservices.com](http://uhcservices.com).

## DO

- Complete the requested amount.
- Include provider name, address and Tax ID (if available).
- Send original copies on white paper. Carbon copies and colored paper are not legible when scanned.
- Circle names and dollar amounts on receipts.
- Tape small receipts to a standard 8.5" x 11" sheet of blank paper. Ensure print is legible.
- Attach itemized receipts/documentation to the form.
- Read Certification for Reimbursement; sign/date form.
- Make a copy of form and documentation for your personal records.

## DO NOT

- Do not submit cancelled checks or credit card receipts alone. These are not adequate documentation without supporting itemization.
- Do not highlight names, prices or dates on receipts. They are not legible when scanned.
- Do not handwrite item names on receipts. These are not acceptable.

Part 1 Employee Information (Please print) Itemize each expense using separate entries below. Use additional forms as necessary.		
Employee name (Last and first)	Member ID (SSN or unique ID)	Daytime telephone no.
Mailing address, City, State, ZIP Code	Employer name	
	Employee email	
<i>Please notify your benefits administrator of any address changes</i>		

Part 2 Dependent Care Expenses (Please print) itemize each expense using a separate line. Use additional forms as necessary.						
Dependent/Child's Name	Relationship	Date of Birth – mm/dd/yyyy	Type of Dependent/Child Care Service	Date(s) of Service – mm/dd/yyyy		Request Amount
				From:	To:	
				From:	To:	
				From:	To:	
				From:	To:	
				From:	To:	
<b>Dependent/Child Care Expenses Subtotal</b>						
<b>Total Request For Reimbursement</b>						<b>\$</b>

Part 3 Day Care Provider's Certification of Services Rendered (Please print)	
I, the signer below, certify that the services listed in Part 3 above, were rendered by me and charges incurred have been paid for.	
Day Care Provider and Company Name:	Day Care Provider's Address:
Day Care Provider's Tax Id#:	Day Care Provider's Signature and Title:

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Certification For Reimbursement**

This statement should read: I certify that any expenses for which I am requesting reimbursement from my Dependent Care FSA, as itemized above, were incurred by my eligible dependents as permitted under the Dependent Care FSA, and have not been reimbursed and I will not seek reimbursement under any other plan. I understand that the expenses reimbursed through the FSA program cannot be used to claim any federal income tax deduction or credit. To the best of my knowledge and belief, my statements are complete and true.