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Dependent Care Receipt Form

Dear Dependent Care Provider:

The person named below is a participant in an employer sponsored Dependent Care Flexible Spending Account. The participant is requesting reimbursement from this pretax account for qualified dependent care expenses paid to you, the dependent care provider.

Company Name		**Plan Year**	
Employee Name		**Online Claim Reference Number or Employee Number**	

The IRS requires that a proof of services (e.g. receipt) be provided by you, the care provider. Please use this form as that receipt by verifying or completing the Provider Information section and signing below.

Provider Information:

Care Provider Name		**Tax ID #/SSN**	
Service Span Date	From: To:	**Total Amount Paid**	$
Dependent name(s) receiving care:			

I verify that all information contained on this form regarding my dependent care services provided to the employee named above is accurate, and applicable amounts have been paid.

Care Provider Signature		**Date**	