DEPENDENT CARE REIMBURSEMENT REQUEST

MUTUAL HEALTH SERVICES℠

SUBMIT CLAIMS TO :	**MUTUAL HEALTH SERVICES** **P.O. BOX 5700** **MZ: 04-2W-8610** **CLEVELAND, OHIO 44101**
phone (330)666-0337 **fax (330)666-2845**	**toll free 800-367-3762 ext 14535** flex@mutualhealthservices.com

****EMPLOYEE INSTRUCTIONS****

1. COMPLETE PARTS A & B IN FULL
2. PLEASE HAVE YOUR DAYCARE PROVIDER SIGN THE ITEMIZATION OF CHARGES

WE CANNOT CONSIDER FUTURE DATES OF SERVICE.

PART A FAILURE TO ANSWER ALL QUESTIONS MAY CAUSE DELAY IN PAYMENT

ADDRESS CHANGE ? (PLEASE CIRCLE) YES NO

EMPLOYEE NAME (FIRST,MIDDLE,LAST) | STREET ADDRESS | CITY | STATE | ZIP CODE

DATE OF BIRTH	EMPLOYER	SOCIAL SECURITY NUMBER

DEPENDENT NAME(S)	SEX (PLEASE CIRCLE)	DATE OF BIRTH		RELATIONSHIP TO EMPLOYEE
1	MALE FEMALE			
2	MALE FEMALE			
3	MALE FEMALE			
4	MALE FEMALE			

PART B PER IRS REGULATION, ALL INFORMATION BELOW IS REQUIRED

NAME OF PROVIDER | ADDRESS

PROVIDER'S TAX I.D. NUMBER OR SOCIAL SECURITY NUMBER :

PLACE WHERE CARE RENDERED (PLEASE CIRCLE)

EMPLOYEE'S HOME | LICENSED FACILITY | OTHER

IF MORE THAN 6 CHILDREN - IS FACILITY LICENSED? YES NO (PLEASE CIRCLE)

RELATIONSHIP OF PROVIDER TO EMPLOYEE (PLEASE CIRCLE)

NONE | PARENT | DEPENDENT CHILD * BIRTH DATE:___/___/___ | OTHER FAMILY MEMBER

PLEASE NOTE THE IRS REQUIRES DEPENDENT PROVIDER TO BE AT LEAST 19 YEARS OF AGE

DATES OF SERVICE _____/_____/_____ THRU _____/_____/_____ TOTAL CHARGES: $_____

YOUR PLAN HAS A 2 1/2 MONTH GRACE PERIOD. ANY CHARGES INCURRED WITHIN THE GRACE PERIOD WILL BE PROCESSED FROM ANY EXISTING PRIOR YEAR FUNDS FIRST.

I certify that dependent care expenses were incurred to allow myself and/or spouse to be employed outside the home. I understand that dependent care expenses form my Dependent Care Account cannot be claimed as a Child Care Tax Credit on my Federal Income Tax Return.

_____ _____/_____/_____

EMPLOYEE SIGNATURE | DATE

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