



# FLEXIBLE SPENDING CLAIM FORM

## Dependent Care Reimbursement (DCRA)

**SEND TO:**  
**Meritain Health**  
**1980 Detroit Road**  
**Cleveland, Ohio 44116-1816**

**EMPLOYER** \_\_\_\_\_

**About the Employee:** For ALL claims - this area must be filled out completely

|  |  |       |                |                          |   |
|--|--|-------|----------------|--------------------------|---|
| EMPLOYEE   | Employee's Name (Please Print Full Name) |       |                | Member's ID Number       | <input style="width: 100%;" type="text"/> |
|  | Last                                     | First | Middle Initial | Employee's Date of Birth |   |
|  | Address                                  |       |                | Month / Day / Year       |   |
|  | City                                     | State | Zip            | Daytime Telephone Number |   |
| <b><i>New address? Contact your employer's personnel office to make the appropriate changes</i></b>  |  |       |                |                          |   |
| <p>Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud, submits an application for coverage or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. I certify that I have incurred the expenses for which reimbursement is claimed for the Flexible Spending Account and I further declare that I have not and will not claim credit for these expenses on my individual income tax return.</p> |  |       |                |                          |   |
| Signature (Required)   |  |       | Date           |                          |   |

**Items Submitted for Reimbursement from your Dependent Care Reimbursement Account (DCRA) for Licensed Providers**

|                       |  |                      |                                     |  |  |       |  |     |  |
|-----------------------|--|----------------------|-------------------------------------|--|--|-------|--|-----|--|
| LICENSED PROVIDERS    | Attach <b>Itemized receipts</b> for dependent care reimbursement.  |                      |                                     |  | <b>PLEASE NOTE:</b><br>IRS guidelines prohibit pre-payment for future dates of service. Please be sure the provider breaks down dates of service so you may be reimbursed in a timely fashion. |       |  |     |  |
|                       | <b>INFORMATION REQUIRED ON ITEMIZED RECEIPTS INCLUDE:</b>  |                      |                                     |  |  |       |  |     |  |
|                       | (1) Name and Date of Birth of dependent.   |                      |                                     |  |  |       |  |     |  |
|                       | (2) Name, Address and Tax Identification number of provider.   |                      |                                     |  |  |       |  |     |  |
|                       | (3) Dates of Service and Cost.   |                      |                                     |  |  |       |  |     |  |
|                       | <b>Complete the following information section if your day care receipt does not reflect the required information</b> |                      |                                     |  |  |       |  |     |  |
| Name of Provider      |  |                      |                                     | Provider's Social Security/Tax ID Number |  |       |  |     |  |
| Address               |  |                      |                                     | City                                     |  | State |  | Zip |  |
| <b>Dependent Name</b> |  | <b>Date of Birth</b> | <b>Dates of Service (From - To)</b> |  | <b>Cost</b>  |       |  |     |  |
|                       |  |                      |                                     |  |  |       |  |     |  |
|                       |  |                      |                                     |  |  |       |  |     |  |
|                       |  |                      |                                     |  |  |       |  |     |  |

**for Unlicensed Providers**

|   |                       |  |                      |                                     |  |             |       |  |     |  |
|---|-----------------------|--|----------------------|-------------------------------------|--|-------------|-------|--|-----|--|
| OTHER PROVIDERS   | Name of Provider      |  |                      |                                     | Provider's Social Security/Tax ID Number |             |       |  |     |  |
|   | Address               |  |                      |                                     | City                                     |             | State |  | Zip |  |
|   | <b>Dependent Name</b> |  | <b>Date of Birth</b> | <b>Dates of Service (From - To)</b> |  | <b>Cost</b> |       |  |     |  |
|   |                       |  |                      |                                     |  |             |       |  |     |  |
|   |                       |  |                      |                                     |  |             |       |  |     |  |
|   |                       |  |                      |                                     |  |             |       |  |     |  |
| FICA and FUTA taxes on wages paid to a Day Care Provider                  |                       |  |                      |                                     |  |             |       |  |     |  |
| Room and Board expenses incurred outside the home for a Day Care Provider |                       |  |                      |                                     |  |             |       |  |     |  |
| Other (list) _____  |                       |  |                      |                                     |  |             |       |  |     |  |
| <b>TOTAL</b>  |                       |  |                      | <b>\$</b>                           |  |             |       |  |     |  |

**Section 129 of the Internal Revenue Code requires that an expense satisfy each of the following requirements to be eligible for reimbursement:**

- |  |   |
|--|---|
| <p>(1) The expense must be incurred by you during a period when you have a dependent or spouse who is a "qualified individual" - whom is either:</p> <p>(a) a dependent under age 13 and whom you are entitled to an income tax deduction; or</p> <p>(b) a dependent or spouse, regardless of age, who is incapable of caring for himself/herself and spends 8 hours each day in your household.</p> | <p>(2) If the expense is for services provided outside your household, at a Dependent Car Center which provides care for at least six non-residents, it must:</p> <p>(a) comply with all state and local laws;</p> <p>(b) charge a fee for providing the services.</p> <p>(3) Special rules apply to divorced parents or married individuals living apart. Consult your tax preparer.</p> |
|--|---|

**If you require assistance in presenting this claim, call your Service Delivery Team at the number listed on your healthcare I.D. card.**