WageWorks®

www.wageworks.com

Dependent Care Account

Pay Me Back Claim Form

DO NOT USE A FAX COVER SHEET
to ensure speedy processing.

TOLL-FREE FAX: (877) 353 - 9236

Or, mail to: Claims Administrator, PO Box 14053, Lexington, KY 40511

ACCOUNT HOLDER INFORMATION

Last Name

First Name

Soc. Sec. # (last 4 digits)

Employer / Program Sponsor's Name

Zip Code

Birth Month/Day (MM/DD)

Email Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

I certify that the information on this page is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by an eligible dependent while I was a participant in the plan. These services have already been provided and I have not and will not seek reimbursement of this expense from any other plan or party. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com (available upon registration; enter user name and password or click on First Time User? link).

Signature of Account Holder X _____ **Date** _____

CLAIMS FOR OUT-OF-POCKET EXPENSES

Dependent's Name

Child care ◯ Before/after school ◯
Preschool ◯ Summer day camp ◯
Au pair ◯ Senior day care ◯
Other: _____

1

Provider's Name

Service Start Date (MM/DD/YY)

$ Out-of-Pocket Cost

Provider's SSN or Tax ID#

Service End Date (MM/DD/YY)

Signature of Provider X _____ **Date** _____

Certifies services provided. Not required. Replaces need for receipt or other proof of service.

Dependent's Name

Child care ◯ Before/after school ◯
Preschool ◯ Summer day camp ◯
Au pair ◯ Senior day care ◯
Other: _____

2

Provider's Name

Service Start Date (MM/DD/YY)

$ Out-of-Pocket Cost

Provider's SSN or Tax ID#

Service End Date (MM/DD/YY)

Signature of Provider X _____ **Date** _____

Certifies services provided. Not required. Replaces need for receipt or other proof of service.

YOU MUST HAVE PROVIDER SIGN FORM OR INCLUDE A RECEIPT OR OTHER APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.

$

TOTAL THIS FORM

MORE EXPENSES? Complete another form.