



# Dependent Child Care FSA Claim Form

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### Tips to Remember when submitting Dependent Child Care FSA expenses.

1. **Include your 10-digit FlexID.** Locate your FlexID at [www.flexdirect.adp.com](http://www.flexdirect.adp.com) or by calling the Participant Solution Center at 1-800-654-6695.
2. Sign and date your Claim Form. Claim forms without signatures cannot be processed.
3. Fax your Claim Form *without* a cover page or instruction pages. Attach proof of expense(s) or have your dependent care provider sign where indicated.
4. **NOTE:** Do not submit claims for future begin or end dates. Dependent Care claims should be listed with each Claim Service Period as a separate line item. Claim Service Periods for Dependent Care expenses are typically weekly or monthly.

## Employee Information

(PLEASE PRINT)

Name Employer Name

(Please print name in ALL CAPITAL letters)

Address

City State Zip Daytime Phone

**FlexID**

FlexID input field with dotted grid

Instructions: Please use blue or black ink and print like this



0 1 2 3 4 5 6 7 8 9

### Beginning Date of First Claim Service Period:

Enter Beginning Date of First Claim Service Period as MM-DD-YY.

MM - DD - YY input boxes

If submitting multiple Claim Service Periods, use the beginning date for the earliest Claim Service Period submitted on this form.

Ending Date of Each Claim Service Period			NOTE: Please report <u>only one</u> Claim Service Period per block. Combining multiple expenses in one block may result in a delayed reimbursement.	Amount for Each Claim Service Period	
MONTH	DAY	YEAR		DOLLARS	CENTS
[Dotted Grid]			NAME OF PROVIDER		[Dotted Grid]
			TAXPAYER ID OR SSN OF PROVIDER<OPTIONAL>	DEPENDENT D.O.B.	
[Dotted Grid]			DEPENDENT NAME		[Dotted Grid]
			RELATIONSHIP TO EMPLOYEE		
[Dotted Grid]			NAME OF PROVIDER		[Dotted Grid]
			TAXPAYER ID OR SSN OF PROVIDER<OPTIONAL>	DEPENDENT D.O.B.	
[Dotted Grid]			DEPENDENT NAME		[Dotted Grid]
			RELATIONSHIP TO EMPLOYEE		
[Dotted Grid]			NAME OF PROVIDER		[Dotted Grid]
			TAXPAYER ID OR SSN OF PROVIDER<OPTIONAL>	DEPENDENT D.O.B.	
[Dotted Grid]			DEPENDENT NAME		[Dotted Grid]
			RELATIONSHIP TO EMPLOYEE		
[Dotted Grid]			NAME OF PROVIDER		[Dotted Grid]
			TAXPAYER ID OR SSN OF PROVIDER<OPTIONAL>	DEPENDENT D.O.B.	
[Dotted Grid]			DEPENDENT NAME		[Dotted Grid]
			RELATIONSHIP TO EMPLOYEE		

To Expedite Processing Please Fax Your Claim To  
 1- (866) 392-4090 (toll-free)  
 Or Mail to: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853

**Total Expenses** → \$ [Dotted Grid]

### Dependent Care Provider Certification (Necessary only if receipt is not provided)

I certify that the services for the above noted service period(s) and cost(s) have been incurred by the claimant and that I have not previously certified these expenses.

SIGNATURE

Signature line with dotted grid

DATE

Date line

### Certification

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me or by my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement under any other source. Additionally, these expenses are not being claimed as tax deductions under the IRS code. I certify that any Dependent Care Provider Certification above was provided by a valid Dependent Care Provider.

SIGNATURE

Signature line with dotted grid

DATE

Date line