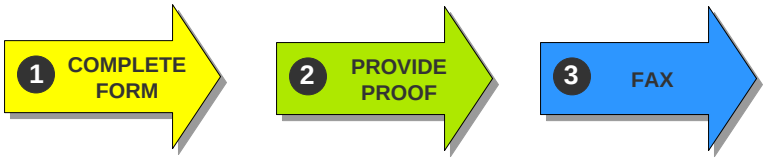
Submitting Your FSA Dependent Care Claim

How To File a Dependent Care Claim

To complete a Dependent Care reimbursement request (a claim), you must submit a *Dependent Care Claim Form* along with an itemized receipt or provider certification that clearly shows an eligible service was provided. To complete a Dependent Care expense reimbursement, please:

1. Complete *a Dependent Care Claim Form*
2. Attach itemized receipt(s) or have your Dependent Care Provider certify the expense(s)
3. Send us the Form and the receipt(s)



The *Claim Form* must be completed entirely, dated and signed. Receipts must state the provider name, provider contact information, the dependent name, service dates (begin and end), a description of the service and the expense amount. A credit card receipt or canceled check is not adequate documentation. Credit card receipts often do not list the service provided along with a description of the service. This is why you must save your itemized receipts.

If your Dependent Care provider does not give receipts, you must have the provider fill in the begin and end dates for the service period(s), read the certification and sign and date the form where indicated. When using a provider signature as proof of expense, the provider's taxpayer ID or Social Security Number must be provided in the Expense Information section of the form. Dependent Care claims cannot be reimbursed without proper receipts or provider certification.

You may submit up to four (4) expenses on a single Dependent Care Claim Form, using a separate line for each expense. Please fax (fastest process) OR mail the documents (keep a copy) but please **DO NOT DO BOTH**.

Place the documents in this order: Dependent Care Claim Form first, then the receipt, if available. Please do not return the instruction pages with your Claim.

Fax: 866-392-4090 (toll-free) or 678-762-5900.

OR

Mail: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853.

Good Receipt

Happy Kids Day Care
125 Main Street
Smallville, CA 12345
(999) 555-1313

Billing For: Sara Sample
1414 Elm Street
Smallville, CA 12345
Child Name: Jeffrey Sample

Dates	Service Type	Amount
January 4 – 8, 2001	Daily Child Care, toddler group	$ 375.00

Receipt Missing Information

Happy Kids Day Care
125 Main Street
Smallville, CA 12345
(999) 555-1313

DATE: 01-08-2001 TIME: 05:43PM

ITEM: 0041 VIS SALE
ACCT: XXXXXXXXXXX9876
AUTH: 9898

TOTAL: $375.00

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO CARD ISSUER AGREEMENT (MERCHANT AGREEMENT IF CREDIT VOUCHER)

x _____

no description of items purchased

Why Providing Documentation Is Important

The IRS has provided strict requirements stating that expenses reimbursed through a Flexible Spending Account be substantiated using itemized receipts or provider certification. All supporting documentation must reflect the provider name, provider contact information, dependent name, service dates (begin and end), a description of the service(s) and the expense amount(s). Dependent Care claims submitted without proof of expense cannot be approved for payment, per IRS regulations. If your claim is declined for improper proof of expense, or if the expense is deemed as ineligible, you will be notified by ADP via U.S. Mail Service.

Additional Information and Resubmitting an FSA Claim

Important Information About Dependent Care Claim Service Periods and Expense Reimbursement

IRS regulations place strict guidelines on reimbursements for Dependent Care expenses. The biggest point of confusion in these regulations is the difference between when an expense is paid versus when an expense is "incurred". Per IRS regulations, expenses must be fully "incurred" prior to receiving reimbursement. This means the service must have been fully provided and completed for the claim service period. This is an important point for Dependent Care expenses because most providers require payment at the beginning of the service period. Remember, a claim service period is the timeframe for which services have been received, you have paid the provider and reimbursement is being requested. Claim service periods for Dependent Care expenses are typically weekly or monthly. Consider the following scenario:

Sara has a young son, Jeffrey, in daycare. Sara uses daycare services while she works, Monday – Friday. She pays her daycare provider weekly on Mondays. When she takes Jeffrey to daycare on Monday, January 4, she pays the provider for the week. The service period for which she is paying is Monday, January 4, through Friday, January 8. She is paying for services in advance.

According to IRS regulations, Sara cannot receive reimbursement for this expense prior to January 9, after the service period (January 4 – 8) has been completed and all services for that period have been provided in full. It is at this point that expenses have been fully "incurred".

Under these regulations, it is important that your receipts indicate the full service period covered by the payment, including begin date and end date. When completing your Dependent Care Claim Form, you should be sure to indicate the earliest begin date for **all** the service periods you are submitting for reimbursement and indicate the ending service date for **each** service period (see Page 3 for complete instructions).

For additional information on Dependent Care reimbursements, please visit www.flexdirect.adp.com.

NOTE: The FSA Card may not be used to pay for Dependent Care expenses.

Resubmitting an FSA Claim When Additional Information is Requested

On occasion, you may be asked to resubmit a claim because information you provided was insufficient or you neglected to sign the claim form. In the event you are asked to resubmit a claim, you must submit a new claim form with the requested information.

Depending on the situation, it may not be necessary to resubmit the entire claim. For example, if you filed a claim with four expenses and **only one expense required additional information**, you would file a new claim for that one expense with its supporting documentation. You should not resubmit the entire claim with all four expenses as this will result in duplicating the other three expenses and you would receive a letter indicating that these expenses had been duplicated. However, if you **forgot to include receipts** or if you **neglected to sign your claim form**, it would be necessary to resubmit the entire claim with all its supporting documentation.

For questions or additional information on resubmitting claims, please visit www.flexdirect.adp.com.

Filing Multiple Expenses with the Same Service Date, Same Amount

There may be times when you need to submit multiple expenses for the same amounts that were incurred on the same date. For example, you have two children who are both in daycare. Both children have identical daycare expenses for the same service period. The ADP Claim System categorizes claims based on the service date and amount and compares the date and amount to claims you have already submitted. By filing a separate claim form for each child, the claim that is received and processed second will be marked as a duplicate claim. Therefore, when submitting multiple claims with the identical service date and amount, you should submit the expenses on the same claim form, whenever possible. This will avoid having eligible expenses being inadvertently marked as duplicate claims.

In the event a valid claim is entered as a duplicate, please contact your Participant Solution Center to have the claim status corrected. You will receive a notification when a claim is marked as a duplicate. You can also verify the status of your claims at www.flexdirect.adp.com.

Preparing Your FSA Dependent Care Claim Form

Please do not return the instructions pages with your Claim.

The Claim Form is designed so that you may complete the form on your computer by tabbing through the designated fields and typing the required information. If you do not have access to a computer, please use black or blue ink to complete the form. Print clearly and only in the spaces provided. This form will be processed electronically.

Step 1: **Complete all Employee Information completely.** When completing the Employee Information, you should:

1. Provide your name as it appears on your paycheck. Please print your name in ALL CAPITAL letters.
2. Provide your employer's name.
3. Include your complete mailing address.
4. Include a daytime phone number where you can be reached.
5. Include your Social Security Number.

Employee Information (PLEASE PRINT)

Name: SARA SAMPLE (1) (Please print name in ALL CAPITAL letters)

Employer Name: ABC Company (2)

Address: 1234 Main Street (3)

City: Anytown (3) State: US (3) Zip: 12345 (3) Daytime Phone: 555-222-1234 (4)

Social Security Number (5): 9 8 9 7 9 6 9 5 9

Instructions: Please use blue or black ink and print like this → 0 1 2 3 4 5 6 7 8 9

Step 2: **Complete the Expense Information.** Be sure to include only one Claim Service Period per line provided. **DO NOT** combine multiple expenses on one line. The Claim Form allows you to submit up to four (4) expenses per form. Begin and End dates should match the dates on your receipt, if provided. When completing the Expense Information, you should:

1. Provide the Beginning Date of Service for the earliest Claim Service Period you are submitting for reimbursement on this claim form.
2. Provide the last date services were provided for each Claim Service Period.
3. Provide the name of the provider from whom the service was received.
4. Provider the taxpayer ID or Social Security Number of the Dependent Care Provider. This information is required when no receipt is available and you are using the provider signature as proof of expense.
5. Provide information on the dependent for whom the service was provided: name, date of birth and the dependent's relationship to you (use "C" for child, "S" for Spouse or "O" for other).
6. Provide the total amount for the service.
7. Provide the total amount for all line items on this Claim Form.

☆ **Faxing your claim package is the best submission route and will result in the quickest reimbursement.**

Beginning Date of Claim Service Period (1): Enter Beginning Date of Claim Service Period as MM-DD-YY. → 0 1 - 0 4 - 0 1

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 (2)			NOTE: Please report only one 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
0 1	0 8	0 1	NAME OF PROVIDER (3): Happy Kids Day Care		3 7 5	0 0 (6)
			TAXPAYER ID OR SSN OF PROVIDER (4): 123-45-6789	DEPENDENT D.O.B. (5): 01/21/1998		
			DEPENDENT NAME (5): Jeffrey Sample	RELATIONSHIP TO EMPLOYEE (5): C		
			(7) Total Expenses →		$ 3 7 5	0 0

Step 3: **Have the Dependent Care Provider certify the Claim.** Provider certification is only required if receipts are not available.

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

I certify that the services for the 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: *Pamela Provider* DATE: 01/08/01

Step 4: **Sign and date your Claim Form.** Claim forms received without an authorizing signature cannot be processed.

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: *Sara Sample* DATE: 01/11/01

FSADC-01

Dependent Care Spending Account Claim Form

This document and any attachments are intended solely for the use of the sender and ADP and may contain information that is privileged and confidential. If you are not the intended recipient or its authorized representative, you are hereby notified that dissemination of this information is strictly prohibited. If you received this information in error, notify the sender immediately and destroy this document and all supporting attachments.

Tips to Remember

1. Sign your Claim Form.
2. Fax your Claim Form _without_ a cover page. Attach proof of expense(s) or have your dependent care provider certify where indicated.
3. _Do not_ include the instructions pages with your submission.

NOTE: Dependent Care claims should be listed with each Claim Service Period as a separate line item. A Claim Service Period is the timeframe for which services have been received, you have paid the provider and reimbursement is being requested. Claim Service Periods for Dependent Care expenses are typically weekly or monthly. Do not submit claims for future dates.

Employee Information (PLEASE PRINT)

Name ____________________ Employer Name ____________________

(Please print name in ALL CAPITAL letters)

Address ____________________

City ____________ State ______ Zip ______ Daytime Phone ____________

Social Security Number

Instructions: Please use blue or black ink and print like this ➡ 0 1 2 3 4 5 6 7 8 9

Beginning Date of Claim Service Period: __ __ - __ __ - __ __

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

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 only one 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
			NAME OF PROVIDER			
			TAXPAYER ID OR SSN OF PROVIDER	DEPENDENT D.O.B.		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE		
			NAME OF PROVIDER			
			TAXPAYER ID OR SSN OF PROVIDER	DEPENDENT D.O.B.		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE		
			NAME OF PROVIDER			
			TAXPAYER ID OR SSN OF PROVIDER	DEPENDENT D.O.B.		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE		
			NAME OF PROVIDER			
			TAXPAYER ID OR SSN OF PROVIDER	DEPENDENT D.O.B.		
			DEPENDENT NAME	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 ➡ $

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

I certify that the services for the 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 ____________________ DATE ____________

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 ____________________ DATE ____________