DEPENDENT CARE (DCA) CLAIM FORM

INSTRUCTIONS

Send completed, signed form with all supporting documentation to:

Email: SpendingAccountProcessing_Receipts@alegeus.com

or

Fax: (855) 898-2715

or

Mail: Spending Account Processing
PO Box 162177
Altamonte Springs, Florida 32716

If you have any questions, contact your Member Advocate Team number located on the back of the Member ID Card.

Supporting documentation for dependent care expenses is required only if provider does not sign this form.

EMPLOYEE INFORMATION *(*required fields)*

*Name:	*SSN:
Address:	City, State Zip:
Email:	*Phone:

DEPENDENT CARE EXPENSES *(attach supporting documentation if Provider does not sign form)*

If not signed by the Provider, does your receipt include all of the following?

- Provider's name & address
- Service description
- Date of service
- Patient's name
- Amount billed
- Tax ID
- Dependent Name

******CREDIT CARD RECEIPTS ARE NOT ACCEPTABLE******

Dependent's Name	Age	Service Date From	Service Date To	Name & Address of Provider	Amount
					$
					$
					$
					$
					$
					$
					$
					$
				Total Dependent Care Expenses	**$**

Provider Signature

Provider SSN# or Tax ID#

PARTICIPANT AGREEMENT *(*required fields)*

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other plan including a spending account. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of this plan.

_____ _____

*Participant Signature Date Signed