



DCAP Reimbursement Claim Form

Email to: Flex@hng.com
Fax to: 866-600-7398 or 225-644-9985

<i>Employee Last Name</i>	<i>First Name</i>	<i>MI</i>
<i>Address</i>	<i>Address Line 2</i>	
<i>City</i>	<i>State</i>	<i>Zip</i>
<i>E-Mail Address</i>	<i>Telephone</i>	
<i>Employer</i>		
<i>Social Security Number:</i> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<i>Employee ID Number:</i> _____	

In order to receive reimbursement, all required fields applicable to your claim must be completed. You must attach a bill or receipt showing service dates, cost and the care provider's tax ID or Social Security number or have the provider sign below in the "Provider Signature" section. Cancelled checks are not considered sufficient documentation.

I request reimbursement for the below listed qualified dependent care expenses. I certify that the services for which the expenses have been incurred have been received and the expenses paid. I have included signed copies of their independent provider's charges, which includes the date and amount of the charge.

Signed: _____ Date: _____

Service Date	__/__/__ to __/__/__	__/__/__ to __/__/__	__/__/__ to __/__/__	__/__/__ to __/__/__
Name of Service Provider				
Provider Social Security or Tax ID				
Dependent Name				
Date of Birth				
Requested Amount for Dependent				

I certify that I provided care as specified above.

Dependent Care Provider's Signature _____ Date: _____