



# Dependent Care Account Reimbursement Claim Form

Questions?  
Contact us at:  
(888) 436-0016  
[www.phtech.com](http://www.phtech.com)

## Employee Information

Employer Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Employee Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Reimbursement Request

Name of Dependent	Service Start Date	Service End Date	Name of Provider	Expense Amount
1.				\$
Provider's SSN or Tax ID # _____				
Provider's Signature: _____				
Provider's Address: _____				
2.				\$
Provider's SSN or Tax ID # _____				
Provider's Signature: _____				
Provider's Address: _____				
<b>TOTAL FOR THIS FORM</b>				

**You must attach appropriate documentation for each expense that clearly indicates:** Dates of Service, Name of Provider, the tax ID# or social security number, who the care was for and the amount of the charge (s). We cannot accept cancelled checks, credit card receipts, or money order receipts.

## Authorization

I certify that the information I have provided on this form is correct and complete. All expenses for which reimbursement is claimed have been incurred during the period of coverage for myself, my spouse or for an eligible dependent, as defined under Internal Revenue Code Section 152 (as amended by the Working Families Tax Relief Act of 2004). These expenses have not been reimbursed and I will not seek reimbursement for these expenses under any other plan covering health benefits. I understand that I cannot use expenses reimbursed through the healthcare account as tax deductions when filing income tax returns.

\_\_\_\_\_  
Employee Signature (required)                      Date                      Total number of pages faxed: \_\_\_\_\_

**Please send claims to:**  
PH Tech, PO Box 5308, Salem, OR 97304  
Email to [fsa@phtech.com](mailto:fsa@phtech.com)  
Fax to 503.315.4137  
Please visit us at our website at [www.phtech.com](http://www.phtech.com).