DAY CARE REIMBURSEMENT REQUEST

(USE THIS FORM TO SUBMIT CLAIMS BY FAX OR MAIL)

(To send scanned claims go to: https://secure.abpmtpa.com/flexupload ***)***

FAX: 406-523-3149 or **TOLL FREE FAX:** 877-424-3539

PHONE: 406-721-2222 or **TOLL FREE PHONE:** 877-424-3570

Please visit www.allegianceflexadvantage.com for additional forms.

Return FAX # _____

Return Phone # _____

PAGES: _____ including this cover sheet

Comment Box

Attention:

Please use black or dark blue ink. Do not use highlighter, red ink or gel pens. DO NOT include medical, dental or vision expenses on this form.

Company: (Print) _____
(Required)

Employee Name: (Print) _____ Participant ID: _____
(Required) **(Last Four Numbers Required)**

Please see reverse side for definition of eligible dependents.

Use one service line for each different provider. List the first name of each child in care, service dates and fees charged.

Dates Incurred	Fees Charged	Individual(s) in Care	Provider	Provider Signature (If no receipt or bill attached)
___/___/___ to ___/___/___	$ _____	_____	**Name**_____	_____
		_____	Tax ID_____	
___/___/___ to ___/___/___	$ _____	_____	**Name**_____	_____
		_____	Tax ID_____	
___/___/___ to ___/___/___	$ _____	_____	**Name**_____	_____
		_____	Tax ID_____	
___/___/___ to ___/___/___	$ _____	_____	**Name**_____	_____
		_____	Tax ID_____	

IF YOUR PROVIDER DOES NOT SIGN THE CLAIM FORM YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF THE EXPENSES WITH THIS CLAIM FORM. PLEASE ATTACH A STATEMENT OF YOUR ACCOUNT, A BILL OR A RECEIPT FROM YOUR PROVIDER.

I certify that the services described on this claim form were necessary for my employment or the employment or education of my spouse. The services were provided for my qualified dependents. The dates and fees are true representations, and I have not sought to be reimbursed elsewhere for these expenses.

Employee Signature: _____ Date: _____
(Required)

☐ Check here if your address has changed. Please list to the right. New Address:

_____

_____

FILING A CLAIM

- Eligible dependents are:
  - Your children that live with you and are under thirteen (13) years of age; or
  - Your tax dependents incapable of self-care that reside in your home at least eight (8) hours per day.

- A flexible benefits dependent care account is available to you and your spouse if necessary for you both to remain gainfully employed or for you to remain gainfully employed while your spouse maintains full-time student status. A dependent care account is also available to single parents.

- The care can be provided through babysitters, live-in care, and/or licensed day care centers.

Ineligible expenses are:

- Expenses paid for care to your spouse or one of your children under the age of nineteen (19).

- Schooling expenses for the kindergarten level and above.

- Overnight camp.

- Nursing homes.

- Meals or other expenses billed separately.

- Transportation from any source other than the provider.

You may attach a bill or a receipt from your provider to this claim form or simply have your provider sign the front of this form on the appropriate line(s).

If you have any questions about filing claims, please call Allegiance at the number listed on the front of this form.