DCA CLAIM SUBMISSION INSTRUCTIONS

Use this instructional document to learn how to request payment Dependent Care Flexible Spending Account (DCA) eligible expenses that have been:

- Already paid out of pocket, **OR**
- Billed directly to you from your provider, and still need to be paid to your provider

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How do I submit my claim?

Please visit the portal to file your claim and upload your supporting documents and online:
www.plansource.wealthcareportal.com

If you choose to submit by mail or fax, send the completed and **SIGNED** form and supporting documentation to

Fax: (877) 767-8804 **Mail:** PO Box 160940
Altamonte Springs, FL 32714

INSUFFICIENT DOCUMENTATION MAY RESULT IN A DENIED CLAIM

What do I need to provide for my Dependent Care Account (DCA) Claim?

All documentation attached **MUST** have a detailed explanation of the following information:

- Date of Service (must fall within dates of plan year for which you are enrolled), **AND**
- Provider Name, **AND**
- Type of Service, **AND**
- Amount charged for the service, **AND**
- Provider's Tax ID or SSN

How long does my claim take to process?

We do our best to process claims as quickly as possible. Depending on your claim type, documents submitted, and number of claims submitted, processing may take up to 3 business days. This does not include reimbursement time which may take additional time depending on your reimbursement method.

INSUFFICIENT DOCUMENTATION MAY RESULT IN A DENIED CLAIM

KEEP A COPY OF ALL CLAIMS SUBMITTED FOR YOUR RECORDS

Dependent Care (DCA) Reimbursement Form

PLANSOURCE

STOP Using this paper claim form is **not the fastest option.**
For faster reimbursement, submit claims online:
www.plansource.wealthcareportal.com

*If you choose to submit by mail or fax, send this completed and **SIGNED** form with all supporting documentation to the below contacts.*

INCOMPLETE/UNSIGNED FORMS OR INSUFFICIENT DOCUMENTATION WILL RESULT IN DENIAL.

Fax: (877) 767-8804 **Mail:** PO Box 160940, Altamonte Springs, FL 32714

Contact Information *(*required fields)*

Employee Name* Member ID*

Employer Name*

Employee Address*

City, State, Zip*

Unreimbursed Expenses (Attach supporting documentation)

Submitted documentation **MUST** contain (please check that all are included):

- ☐ Date of Service (*date must fall within dates of plan year for which you are enrolled)*
- ☐ Provider Name
- ☐ Type of Service
- ☐ Amount

****CREDIT CARD RECEIPTS, or NON-ITEMIZED receipts/statements are not acceptable**

****For a list of eligible expenses under your plan, please refer to your plan documents provided by your insurance carrier.**

Date of Service	Name of Service Provider	Description of Services	Amount
From: / To:			$
From: / To:			$
From: / To:			$
From: / To:			$
		Total Dependent Care Expenses	$

COMPLETE BELOW SECTION ONLY IF YOU ARE NOT PROVIDING RECEIPTS

SIGNATURE OF DEPENDENT CARE PROVIDER

X

DEPENDENT CARE PROVIDER'S NAME SSN OR TAX ID

DATE OF SERVICE

From: To: Amount $

Employee Certification *(claim will not be processed without signature below)*

To the best of my knowledge and belief, my statements for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction or credit. If there is a discrepancy between the total amount of expenses requested below and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Signature Date