WageWorks®

www.wageworks.com

Dependent Care Account

Pay Me Back Claim Form

WageWorks Pay Me Back Dependent Care Claim Form Instructions

PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM FORM

Your claim is important to us. To ensure we are able to approve your claim, please fully complete the WageWorks Dependent Care Pay Me Back Claim Form. Submit your claim form along with your complete documentation of the expense. Please review the guidelines listed below to ensure all necessary information is included when filing your claim.

**** An electronic claim may be submitted at www.wageworks.com. Log in to your account to verify access to this functionality.****

Tips for Filling out the Pay Me Back Claim Form

- Read every box and provide all requested information pertaining to you and your claim.
- Provide the legal name your employer has for you in their official records, not your nickname.
- Provide your ID Code which is usually the last four digits of your SSN.
- Make sure you sign the form. If the **account holder's signature** is not present, we cannot process your claim.
- Dependent Care Provider's signature can be substituted for a receipt from the provider; however, the provider must sign the form where indicated. Either the provider's signature on the claim form **or** an itemized receipt from the provider is required, not both.
- At the end of the tax year, you are required to provide IRS with the provider name, address and Tax ID # on Tax Form 2441 in order to obtain the tax advantage for these expenses.

Things to Remember When Submitting Receipts

- The receipt or documentation must contain:
  - **Provider Name** – Facility name or person who provided the service.
  - **Dates of Service** – Service start and end date for services provided.
  - **Service Description** – Detailed description for services provided.
  - **Amount** – The amount incurred for the services.
  - **Dependent Name** – Person who received the service.
- Cancelled or carbon copies of checks are not acceptable forms of receipt documents. Please do not submit.
- Overnight Camps are not eligible expenses.
- Include a receipt for every expense.
- Handwritten receipts must have stamped provider information.
- Send copies of your receipts; keep the originals for your records.
- If you attach multiple receipt pages, circle or check the dollar amount that is being claimed for each receipt.
- Do not use a highlighter to highlight the dollar amount on the receipt.

Tips for Submitting the Pay Me Back Claim Form

- Do not use a cover page when faxing.
- Please allow 2 business days from receipt of your claim for processing.
- You can verify the claim status online at www.wageworks.com after processing.
- You will be notified via email of the status of your claim if we have a valid email address on file.
- Make a copy of the form and all attachments for your records if submitting via postal mail.
- Do not combine and submit a co-workers claim with yours.

FAX: (877) 353-9236 or Mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

WageWorks®

Dependent Care Account

www.wageworks.com

Pay Me Back Claim Form

****An electronic claim may be submitted at www.wageworks.com.**
Log in to your account to verify access to this functionality.**

DO NOT USE A FAX COVER SHEET
to ensure speedy processing.

TOLL-FREE FAX: (877) 353 - 9236
Or, mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

ACCOUNT HOLDER INFORMATION

Last Name

First Name

ID Code (last 4 digits)*

Employer / Program Sponsor's Name

Zip Code

Birth Month/Day (MM/DD)

Email Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

I certify that the information on this page is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by an eligible dependent (for a child under the age of 13 or other dependents that are physically and mentally incapable of taking care of themselves) while I was a participant in the plan. These services have already been provided and I have not and will not seek reimbursement of this expense from any other plan or party. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com (available upon registration; enter user name and password or click on First Time User? link).

Signature of Account Holder X _____ **Date** _____

CLAIMS FOR OUT-OF-POCKET EXPENSES

1

Dependent's Name

☐ Qualifying Child ☐ Spouse
☐ Qualifying Relative
☐ Other: _____
Relationship to Account Holder

☐ Child care ☐ Before/after school
☐ Preschool ☐ Summer day camp
☐ Au pair ☐ Senior day care
☐ Other: _____

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

$ Out-of-Pocket Cost

Provider's Name

Signature of Provider X _____ **Date** _____

Certifies services provided. Not required. Replaces need for receipt or other proof of service.

2

Dependent's Name

☐ Qualifying Child ☐ Spouse
☐ Qualifying Relative
☐ Other: _____
Relationship to Account Holder

☐ Child care ☐ Before/after school
☐ Preschool ☐ Summer day camp
☐ Au pair ☐ Senior day care
☐ Other: _____

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

$ Out-of-Pocket Cost

Provider's Name

Signature of Provider X _____ **Date** _____

Certifies services provided. Not required. Replaces need for receipt or other proof of service.

* Your ID Code is the last 4 digits of your Social Security Number, your Employee Number or other reference number assigned by your program sponsor. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

At the end of the tax year, you are required to provide the IRS with the provider name, address and Tax ID # on Tax Form 2441 in order to obtain the tax advantage for these expenses.

YOU MUST HAVE THE DEPENDENT CARE PROVIDER SIGN THE CLAIM FORM OR INCLUDE AN ITEMIZED RECEIPT.

MORE EXPENSES? Complete another form.

$ **TOTAL THIS FORM**