FAX: 585-389-7003

Submit or view claims **ONLINE: https://benefits.paychex.com**

Paychex Employee Services: 877-244-1771, available 24/7

FOR OFFICE USE ONLY

Docket # _____

PAYCHEX®

Flexible Spending Account (FSA) Reimbursement Claim
Dependent Care Allowance

EMPLOYEE INFORMATION (print)

Employee Name _____ Company Name _____

Social Security Number _____ Employee Telephone Number (___) _____-_____

E-mail Address _____

Visit **https://benefits.paychex.com** at any time to submit claims **ONLINE** or learn the status of your claim.

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

INSTRUCTIONS CHECKLIST:

- ☐ **If you are completing the table below,** enclose copies of all itemized bills and/or receipts from your provider. Use blue or black ink only to identify FSA items on receipts. **Do not use highlighter. We will not accept copies of personal checks, cancelled checks, or credit card receipts as verification of service.**
- ☐ Verify that bills and receipts contain:
  - date of service
  - cost of service
  - provider's name
  - provider's federal ID or SSN
  - provider's signature
  - dependent's name and age
- ☐ **If you are not providing receipts, complete the Certification from Provider section** and make sure your Dependent Care Provider signs the form in the space provided.
- ☐ **Sign your claim form** and fax it to the number noted above. Retain a copy for your records.
- ☐ If you prefer, mail your claim to: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000.

Claim	Name of Service Recipient	Age of Service Recipient	Service Date(s)	Service Description	Service Provider	Amount
SAMPLE	Baby Doe	1 year	7/7/07 – 7/14/07	Dependent Care	Ms. Smith	$210.43
01				Dependent Care		$
02				Dependent Care		$
03				Dependent Care		$
04				Dependent Care		$
05				Dependent Care		$
					TOTAL	$

Note: Dependent Care Claims will be reimbursed up to the year-to-date contributions made to your account at the time of submission. If you submit for dates of service in the future or for amounts above your current contribution balance, reimbursement will automatically be issued once the date has passed and/or future contributions have been made for this plan year.

If you have more claims, please complete additional Reimbursement Claim forms.

CERTIFICATION FROM PROVIDER

We certify that we are providing Dependent Care Services for the employee noted above for the

month of _____ in the year of _____ for _____ (Dependent's Name), age _____ (Dependent's Age).

Name of Dependent Care Provider _____

Federal ID or Social Security Number _____

Signature of Dependent Care Provider _____ **Date** _____/_____/_____

CLAIM INFORMATION

I incurred the expenses listed above for reimbursement on behalf of my dependent for reimbursable items under Section 125 of the Internal Revenue Code.

Employee Signature _____ **Date** _____ / _____ / _____