# BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

#### **REQUEST FOR REIMBURSEMENT PREFERRED DEPENDENT CARE ACCOUNT**

Attach a copy of the itemized bill along with proof of payment. All documentation must include the dependent name, description of service provided, date provided, and the charge. Be sure to sign and date this form before sending it with all attachments to the address shown.

SECTION 1:	EMPLOYEE INFORMATION	
FIRST NAME	MI LAST NAME	
DATE OF BIRTH	PREFERRED BLUE ACCOUNT NUMBER	Your Preferred Blue Account number is your Blue Cross and Blue Shield of Alabama
MONTH DAY	YEAR PREFIX CONTRACT	contract number. If you do not have your account number, please contact Customer Service at 1 800 213-7930.
COMPANY NAME		ue Cross and Blue Shield of Alabama Visit our web site
		histour neb site
		enefits Service Center www.bcbsal.com
WORK PHONE (Please in		O. Box 11586 • Birmingham, Alabama 35202-1586 for detailed account
		800 213-7930 • Toll Free Fax 1 877 889-3610 information
SECTION 2: DEPENDENT CARE REIMBURSEMENT INFORMATION		
In order to be properly reimbursed, complete this section for each eligible expense and attach all necessary itemized receipts. (PLEASE DO NOT HIGHLIGHT ITEMS ON YOUR RECEIPTS.)		
TYPE SERVICE	FIRST NAME	DATE THE CARE WAS PROVIDED
CHILD DAY CARE		FROM:
ADULT DAY CARE		
BEFORE & AFTER		
SCHOOL CARE		
OTHER ELIGIBLE DEPENDENT CARE	DATE OF BIRTH AGE IN YEARS	
TYPE SERVICE	FIRST NAME	DATE THE CARE WAS PROVIDED
		FROM:
BEFORE & AFTER		
SCHOOL CARE		
OTHER ELIGIBLE DEPENDENT CARE	DATE OF BIRTH AGE IN YEARS	
TYPE SERVICE	FIRST NAME	DATE THE CARE WAS PROVIDED
		FROM:
ADULT DAY CARE		
BEFORE & AFTER		
SCHOOL CARE		
OTHER ELIGIBLE DEPENDENT CARE	DATE OF BIRTH AGE IN YEARS	
TYPE SERVICE	FIRST NAME	DATE THE CARE WAS PROVIDED
CHILD DAY CARE		FROM:
ADULT DAY CARE		
BEFORE & AFTER		
OTHER ELIGIBLE DEPENDENT CARE	DATE OF BIRTH AGE IN YEARS	
	PROVIDER: I certify that I provided the care detailed on this form and h	
payment in the amo	int listed.	
(If no receipt is available)	SIGNATURE OF DCA PROVIDER	DATE SIGNED
SECTION 3: For reimbursement from your Dependent Care Account, please provide the following information.		
PROVIDER'S NAME (DAY CARE, ELDER CARE ETC.) PROVIDER'S SOCIAL SECURITY NUMBER OR TAXPAYER I.D. NUMBER		
		*Required Field
		and that they qualify as deductions as outlined by the Internal Revenue Code. I request
reimbursement up to the limit allowed based on my election. I further certify that these expenses have not been reimbursed and are not reimbursable under any other benefit plan. Dependent must be considered an eligible dependent under the applicable provisions of the Internal Revenue Code.		

SIGNATURE OF EMPLOYEE

DATE SIGNED

**IMPORTANT:** This form is not used to reimburse you for your Blue Cross and Blue Shield of Alabama health benefits. It may only be used to request a payment from a tax-deferred, employee-funded spending account established by your employer under Section 125 of the U.S. Internal Revenue Code. Payments from such an account may only be made for qualified dependent care expenses on behalf of qualified dependents where such expenses have not been reimbursed and are not reimbursable by any other benefit plan.

CL-91 (Rev. 9-2009)

# Tips for Successfully Completing and Filing your Dependent Care

## **Reimbursement Request**

1. Complete your Request for Reimbursement Form legibly. If your form cannot be read, it cannot be processed.

#### 2. Provide appropriate supporting documentation.

If handwriting your reimbursement form, please use black or dark blue ink. Do **not** use highlighter or gel pens. Do not include medical, dental or vision expenses on this form.

**3.** Complete one part of Section 2 for each range of Dates the Care Was Provided and for each dependent.

### 4. Documentation for the DCA Reimbursement must include:

- Name of the dependent for whom the service was provided
- Date(s) of Service: Beginning & End Dates
- Amount that was paid
- Name of daycare provider
- Tax ID number or Social Security Number of the Provider
- Address of the provider

Retain a copy of the documentation and Reimbursement Form in your files.

- 5. "If you do not have a paid receipt from your day care provider you must complete the Affidavit of DCA Provider section on the front of this form.
- 6. Sign your form: An unsigned form will stop your reimbursement!
- 7. Fax or Mail your Form to the contacts listed on the front of the form.

#### **Reimbursement Rules:**

- The DCA expense must be incurred and paid before it can be reimbursed to you.
- Your accumulated payroll deduction amount is the maximum amount you can receive from your DCA
- If your expense is greater than the accumulated payroll deducted amount, you will only receive reimbursement for the accumulated payroll deduction amounts remaining.
- Any expense over the deduction amount will be credited and reimbursed to you after the next payroll deduction.
- You should retain the name, address, and TIN of the service provider. You may be required to report the information on IRS Form 2441 that you attach to your federal income tax return.

## What Expenses Are Eligible?

Eligible expenses that can be paid from the DCA include care provided:

- Inside or outside the home; the care must be provided by someone other than the participant's spouse, or a person listed as the participant's dependent for income tax purposes; or a participant's child under age 19.
- In a dependent care center or a child care center, which meets all applicable state and local regulations.
- By a housekeeper whose services include, in part, providing care for a qualifying individual.

#### To be eligible, a **dependent** must meet the following:

- Must be a child under the age of 13.
- Must be a spouse or qualified dependent that is physically or mentally unable to care for him or herself.
- Must be an elderly parent and qualify as an eligible dependent.

Note: Please refer to the http://www.irs.gov/pub/irs-pdf/p503.pdf IRS publication 503, "Child and Dependent Care Credit" as a guide to covered and non-covered expenses.

