FAX: 585-389-7003

Submit or view claims **ONLINE:** http://www.paychexflex.com

Paychex Employee Services: 877-244-1771
Representatives available Monday – Friday 8:00 a.m. – 8:00 p.m. ET

FOR OFFICE USE ONLY

Docket #

Flexible Spending Account (FSA) Reimbursement Claim
Dependent Care Allowance

EMPLOYEE INFORMATION (print)

Employee Name ______________________________ Company Name ______________________________

Social Security Number (last 4 digits) ______________________ Employee Telephone Number (   ) _________ -

E-mail Address

Visit http://www.paychexflex.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:

- ❑ **Complete the table below and** 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:
  - start and end dates of service
  - provider's name
  - service recipient's age (if dependent under age 13)
  - cost of service
  - service recipient's name
  - Description of Service
- ❑ **For your convenience, in lieu of an itemized receipt, you may have your Dependent Care Provider sign the Certification From Provider section below.** Otherwise, an itemized receipt for your dependent care expenses will be required.
- ❑ **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	Date of Service Start Date	Date of Service End Date	Service Provider	Amount
SAMPLE	Baby Doe	1 year	02/1/2017	02/28/2017	Ms. Smith	$325.00
01						$
02						$
03						$
04						$
05						$
					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 additional 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 service recipients and service dates listed above for the amounts indicated.

Dependent Care Service is care of, or related household services for, a dependent under age 13 or a dependent or spouse that is incapable of self-care and is not for school tuition. Before/after school care is a qualified expense and should be itemized to break out from cost of school tuition if applicable. Expenses incurred by or on behalf of a domestic partner's child are not reimbursable.

Name of Dependent Care Provider ____

Signature of Dependent Care Provider ______________________________ **Date** ________/__________/ ______

CLAIM INFORMATION

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

Employee Signature ______________________________________ **Date** _________/ ________ /