



Please visit [www.abpmtpa.com](http://www.abpmtpa.com) for additional forms.

# DEPENDENT CARE FLEX CLAIM FORM

(USE THIS FORM TO SUBMIT CLAIMS BY FAX OR MAIL)

**FAX:** 406-523-3149 or **TOLL FREE FAX:** 877-424-3539

**PHONE:** 406-721-2222 or **TOLL FREE PHONE:** 877-424-3570

Return FAX # \_\_\_\_\_  
 Return Phone # \_\_\_\_\_

PAGES: \_\_\_\_\_ including this cover sheet

## DEPENDENT CARE REIMBURSEMENT REQUEST

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.

Company: \_\_\_\_\_

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Use one service line for each different provider. List the first name of each child in care, service dates and fees charged.

Provider Name	Individual(s) in Care	Service Dates	Fees Charged	(If no receipt or bill attached) Provider Signature
_____	_____	_____ to _____	\$ _____	_____
_____	_____	_____ to _____	\$ _____	_____
_____	_____	_____ to _____	\$ _____	_____
_____	_____	_____ to _____	\$ _____	_____

IF YOUR PROVIDER DOES NOT SIGN THE CLAIM FORM YOU MUST SUBMIT INDEPENDENT, 3RD PARTY DOCUMENTATION OF THE EXPENSES WITH THIS CLAIM FORM. PLEASE ATTACH A STATEMENT OF YOUR ACCOUNT, A BILL OR A RECEIPT FROM YOUR PROVIDER.

I certify that the services described on this claim form were necessary for my employment or the employment or education of my spouse. The services were provided for my tax dependent child(ren) under the age of 13 years or any elderly/handicapped dependent. The dates and fees are true representations.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Check here if your address has changed. Please list below.

New Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_