DCFSA Claim Form

Dependent Care FSA

Mailing Address:
Consumer Health Solutions
25 Main St. Suite 176 North
Reading, MA 01864

Contact Us:
HealthAccounts@
ConsumerHealthSolutions.com
Leave a Voicemail: 877-230-8650
Fax: 978-451-0981

Instructions: Please attach this form to your claim on the Consumer Health Solutions Portal online (https://CrossAgency.lh1ondemand.com). Please complete the form in its entirety. Failure to do so will result in a request for more information or claim denial.

Account Holder Information:

First Name:	Last Name:	Employer:
Email Address:	Phone:	
Mailing Address Line 1:	Mailing Address Line 2:	
City:	State:	Zip:

Dependent Information:

Name:	Date of Birth:	Relationship:
Name:	Date of Birth:	Relationship:
Name:	Date of Birth:	Relationship:

Expenses Incurred:

Dependent Name	Provider Name	Type of Expense	Date of Service (From-To)	Expense amount
				$
				$
				$
				$

Provider Affidavit:

I hereby certify that the above Dependents Care charges have been incurred. Receipts are not required if the Dependent Care provider provides their signature here.

Provider Signature	Provider Tax ID# (or SSN)	Date

Authorization:

I certify that my eligible dependent(s) have incurred expenses for which reimbursement is sought under my Employer's Dependent Care Flexible Spending Account Plan and that these expenses have been incurred during the Plan Year. I further declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program; Reimbursement cannot be requested until after the last day of the service period. I am solely responsible for the accuracy and veracity of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my Dependent Care Flexible Spending Account.

Employee Signature	Employee Name (Print)	Date

Retain any original receipts or a copy of the claim and receipts for your personal records