

## **WageWorks Dependent Claim Form Instructions**

### **PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM FORM**

Your claim is important. To ensure we are able to process your reimbursement, please fully complete the WageWorks Dependent Claim Form (DC). Submit your claim form along with your complete documentation of the expense. Please review the guidelines listed below to ensure all necessary information is included when filing your claim.

### **Tips for Filling out the Pay Me Back Claim Form**

- Read every box and provide all requested information pertaining to you and your claim.
- Provide the legal name your employer has for you in their official records, not your nickname.
- Provide your ID Code which is usually the last four digits of your SSN.
- Make sure to total all claim line dollar amounts and enter it at the box at the bottom of the form.
- The Provider Tax ID or SSN must be on the form.
- Make sure you sign the form. If the **account holder's signature** is not present, we cannot process your claim.
- **Provider's signature can be substituted for a receipt from the provider however the provider must sign the form if an itemized receipt from the provider is not included. One or the other is required either a provider signed form or an itemized receipt from the provider.**

### **Things to Remember When Including Receipts**

- The receipt or documentation must contain:
  - **Provider Name** – Who delivered the service.
  - **Date of Service** – Date services occurred.
  - **Service Description** – Detailed description of what service or product was paid for.
  - **Amount** – The amount paid for the services.
  - **Dependent Name** – Person who received the service.
- If you are not submitting receipts the provider **MUST** sign the completed form on the provider signature line which is under the dependent name line.
- Cancelled or Carbon copies of checks are not acceptable forms of receipt documents. Please do not submit.
- Overnight Camps are not eligible expenses unless the expenses are broken up into day and night.
- The day expense would be eligible, not the night expenses.
- Include a receipt for every expense.
- If submitting handwritten receipts it must have stamped provider information.
- Do not send your original receipts; save them for the IRS.
- If you attach multiple receipt pages, circle or check the dollar amount that is being claimed for each receipt.
- Do not use a highlighter to highlight the dollar amount on the receipt.

### **Tips for Submitting the Pay Me Back Claim Form by Fax**

- Do not use a cover page.
- Use a high-speed fax machine with a transmission speed of at least 9.6 kbps or 15 sec. per page.
- Please wait 2 business days after submitting your claim before contacting WageWorks for your claim status.
- You can also verify the claim status online at [www.wageworks.com](http://www.wageworks.com).
- You will be notified via email of the status of your claim if we have a valid email address on file.
- Make a copy of the form and all attachments for your records.
- If sending Card Verification Form (CVF) along with your Health Care PMB claim, always put the Card Verification Form in front of the PMB claim so we can process it first.
- Do not combine and submit a co-workers claim with yours.
- Return the original form and copies of your receipts to WageWorks via fax or U.S. Mail.

**FAX: (877) 353-9236, or mail your claims to: Claims Administrator, PO Box 14053, Lexington, KY 40512**

TOLL-FREE FAX: (877) 353 - 9236

Or, mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

**DO NOT USE A FAX COVER SHEET**  
to ensure speedy processing.



### ACCOUNT HOLDER INFORMATION

DOE Last Name      JOHN First Name

1234 ID Code (last 4 digits)\*      ABC COMPANY Employer / Program Sponsor's Name

12345 Zip Code      0913 Birth Month/Day (MM/DD)      JOHN.DOE@ABCCOMPANY.COM Email Address (complete only if new)

### CERTIFICATION AND AUTHORIZATION

I certify that the information on this page is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by an eligible dependent (for a child under the age of 13 or other dependents that are physically and mentally incapable of taking care of themselves) while I was a participant in the plan. These services have already been provided and I have not and will not seek reimbursement of this expense from any other plan or party. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com (available upon registration; enter user name and password or click on First Time User? link).

Signature of Account Holder X [Signature] Date SEPTEMBER 15, 2009

### CLAIMS FOR OUT-OF-POCKET EXPENSES

JOANNA DOE  
Dependent's Name

- Child care
- Before/after school
- Preschool
- Summer day camp
- Au pair
- Senior day care
- Other:

1 CHILD CARE OF PHOENIX

Provider's Name

010109 Service Start Date (MM/DD/YY)

\$ 250000 Out-of-Pocket Cost

123456789 Provider's SSN or Tax ID#

063009 Service End Date (MM/DD/YY)

Signature of Provider X [Signature] Date 9-16-09  
*Certifies services provided. Not required. Replaces need for receipt or other proof of service.*

JONNIE DOE  
Dependent's Name

- Child care
- Before/after school
- Preschool
- Summer day camp
- Au pair
- Senior day care
- Other: ADULT/ ELDER DAY CARE

2 ELDER CARE OF SUPRISE

Provider's Name

090109 Service Start Date (MM/DD/YY)

\$ 300000 Out-of-Pocket Cost

101010963 Provider's SSN or Tax ID#

103109 Service End Date (MM/DD/YY)

Signature of Provider X [Signature] Date 9/13/09  
*Certifies services provided. Not required. Replaces need for receipt or other proof of service.*

\* Your ID Code is the last 4 digits of your Social Security Number, your Employee Number or other reference number assigned by your program sponsor. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

\$ 280000 TOTAL THIS FORM

YOU MUST HAVE PROVIDER SIGN FORM OR INCLUDE A RECEIPT OR OTHER APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.

MORE EXPENSES? Complete another form.