

Dependent Care Pay Me Back Claim Form



- ▶ **File claim online** - Join the growing majority of participants who submit their claim online for faster service. **Log in to your account at www.HealthEquity.com/WageWorks** to file your claim electronically and upload your documentation.
- ▶ **File claim via fax or mail** - Claim forms may also be filed either via fax or US Mail and sent to the following locations:
Fax: 877-353-9236, **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- ▶ **Claim processing time** - Claims will be processed within 2 business days after the form is received. You may check the status of your claim by logging into your account at www.wageworks.com.

ACCOUNT HOLDER:

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

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	DEPENDENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST																												
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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 confirm that by requesting reimbursement here that 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 username and password or click on First Time User? link).