

DEPENDENT CARE EXPENSE CLAIM FORM

Mail to:
UPMC Health Plan
PO Box 3169
Greenwood Village, CO 80155-3169

Phone: 1-888-876-2756
Fax: 1-866-229-3711

No. of pages _____

PLAN & EMPLOYEE INFORMATION

FIRST NAME: _____ LAST NAME: _____ MEMBER ID NUMBER: _____

DAYTIME PHONE : () _____ EMAIL: _____ DATE OF BIRTH: ____/____/____

EMPLOYER NAME: **UPMC** PLAN YEAR: _____

Note: Reimbursements will be sent to the address on file with UPMC. If an address change or update is needed, please contact your Human Resources office or update your information via My HUB.

DEPENDENT CARE EXPENSES

PROVIDER NAME	PROVIDER TAX ID# ¹	PROVIDER ADDRESS, CITY, STATE, ZIP	NAME OF DEPENDENT	SERVICE START DATE	SERVICE END DATE	\$ AMOUNT
						\$
						\$
						\$
						\$
						\$
						\$
¹ Provider Tax ID # or SSN is Required					TOTAL	\$

REIMBURSEMENT INFORMATION

- Please pay this claim by direct deposit to my specified account already on file.
- Please pay this claim by direct deposit using the new information provided below.
- Please issue a check for this claim.

I hereby authorize UPMC Health Plan, Inc. and authorities on its behalf to initiate credit entries for my Flexible Spending Account reimbursements into my account designated below and, if necessary, make corrections for any entries made in error. This authority is to remain in full force and effect until UPMC Health Plan, Inc. has received written notification from me of its cancellation in such time and in such manner as to afford UPMC Health Plan, Inc. a reasonable opportunity to act.

ACCOUNT NUMBER: _____ ROUTING NUMBER: _____

BANK NAME: _____ CHECKING ACCOUNT SAVINGS ACCOUNT

Must be 9 digits

EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the expenses listed above are accurate, complete and are eligible for reimbursement under the plan. I certify that these dependent care expenses have not already been reimbursed under this plan or any other plan and will not be reimbursed under any other employer plans or coverage. I certify that these expenses have not been paid to anyone who is my child or stepchild under the age of 19 and claimed as a dependent on my income tax return. **I understand that I am responsible for acquiring and retaining receipts from my provider for services claimed under this plan. I further understand that I am responsible for reporting the Tax ID# provided above on IRS Form 2441 when I file my Federal Income Taxes.** I certify that if my employer incurs a liability for failure to withhold Federal, State or local, or Social Security Taxes on one or more of my payments or reimbursements that are not Qualified Expenses, I will indemnify and reimburse the employer that liability on demand.

Signature: _____ Date: _____