BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

REQUEST FOR REIMBURSEMENT PREFERRED DEPENDENT CARE ACCOUNT

Attach a copy of the itemized bill along with proof of payment. All documentation must include the dependent name, description of service provided, date provided, and the charge. Be sure to sign and date this form before sending it with all attachments to the address shown.

SECTION 1: EMPLOYEE INFORMATION

FIRST NAME | MI | LAST NAME

DATE OF BIRTH | PREFERRED BLUE ACCOUNT NUMBER

NOTE: *Your Preferred Blue Account number is your Blue Cross and Blue Shield of Alabama contract number. If you do not have your account number, please contact Customer Service at 1-800-213-7930.*

COMPANY NAME | **WORK PHONE** (Please include area code) | **HOME PHONE** (Please include area code)

Blue Cross and Blue Shield of Alabama – Benefits Service Center P.O. Box 11586 • Birmingham, Alabama 35202-1586 • 1-800-213-7930 • Toll Free Fax 1-877-889-3610
Visit our web site **www.bcbsal.com** for detailed account information

SECTION 2: DEPENDENT CARE REIMBURSEMENT INFORMATION

In order to be properly reimbursed, complete this section for each eligible expense and attach all necessary itemized receipts. (PLEASE DO NOT HIGHLIGHT ITEMS ON YOUR RECEIPTS.)

TYPE SERVICE
- ○ CHILD DAY CARE
- ○ ADULT DAY CAR
- ○ BEFORE & AFTER SCHOOL CARE
- ○ OTHER ELIGIBLE DEPENDENT CARE

PATIENT'S FIRST NAME | **LAST NAME**
DATE OF BIRTH | **AGE IN YEARS** | **AMOUNT**
DATE THE CARE WAS PROVIDED - FROM: | **DATE THE CARE WAS PROVIDED - TO:**

TYPE SERVICE
- ○ CHILD DAY CARE
- ○ ADULT DAY CAR
- ○ BEFORE & AFTER SCHOOL CARE
- ○ OTHER ELIGIBLE DEPENDENT CARE

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- ○ OTHER ELIGIBLE DEPENDENT CARE

PATIENT'S FIRST NAME | **LAST NAME**
DATE OF BIRTH | **AGE IN YEARS** | **AMOUNT**
DATE THE CARE WAS PROVIDED - FROM: | **DATE THE CARE WAS PROVIDED - TO:**

AFFIDAVIT OF DCA PROVIDER: I certify that I provided the care detailed on this form and have already received payment in the amount listed.

(If no receipt is available) | **SIGNATURE OF DCA PROVIDER** | **DATE SIGNED** | **TOTAL**

SECTION 3: For reimbursement from your Dependent Care Account, please provide the following information.

PROVIDER'S NAME (DAY CARE, ELDER CARE ETC.) | **PROVIDER'S SOCIAL SECURITY NUMBER OR TAXPAYER I.D. NUMBER**

I certify that the attached expenses are eligible for reimbursement from my designated Dependent Care Account and that they qualify as deductions as outlined by the Internal Revenue Code. I request reimbursement up to the limit allowed based on my election. I further certify that these expenses have not been reimbursed and are not reimbursable under any other plan. Dependent must be considered an eligible dependent under the applicable provisions of the Internal Revenue Code.

SIGNATURE | **DATE SIGNED**

IMPORTANT: This form is not used to reimburse you for your Blue Cross and Blue Shield of Alabama health benefits. It may only be used to request a payment from a tax-deferred, employee-funded spending account established by your employer under Section 125 of the U.S. Internal Revenue Code. Payments from such an account may only be made for qualified dependent care expenses on behalf of qualified dependents where such expenses have not been reimbursed and are not reimbursable by any other benefit plan.

CL-91 (Rev. 12-2013)

Tips for Successfully Completing and Filing your Dependent Care Reimbursement Request

1. **Complete your Request for Reimbursement Form neatly.** If your form cannot be read, it cannot be processed.

2. **Provide appropriate supporting documentation.**
   If handwriting your reimbursement form, 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.

3. Complete one part of Section 2 for each range of dates the care was provided and for each dependent.

4. **Documentation for the DCA Reimbursement must include:**

   - Name of the dependent for whom the service was provided
   - Dates(s) of service, including beginning and end dates
   - Amount that was paid
   - Name of daycare provider
   - Tax ID number or Social Security Number of the provider
   - Address of the provider

   Retain a copy of the documentation and Reimbursement Form in your files.

5. If you do not have a paid receipt from your day care provider you must complete the Affidavit of DCA Provider section on the front of this form.

6. **Sign your form**: An unsigned form will stop your reimbursement!

7. **Submit your form:** Completed forms can be submitted on our website at **www.bcbsal.com**, with the **Alabama Blue** mobile app on your smart phone, by mail, or by fax to our toll-free number.

Reimbursement Rules:

- The DCA expense must be incurred and paid before it can be reimbursed to you.
- Your accumulated payroll deduction amount is the maximum amount you can receive from your DCA
- If your expense is greater than the accumulated payroll deducted amount, you will only receive reimbursement for the accumulated payroll deduction amounts remaining.
- Any expense over the deduction amount will be credited and reimbursed to you after the next payroll deduction.
- You should retain the name, address, and Taxpayer ID Number (TIN) of the service provider. You may be required to report the information on IRS Form 2441 that you attach to your federal income tax return.

What Expenses Are Eligible?

Eligible expenses that can be paid from the DCA include care provided:

- Inside or outside the home; the care must be provided by someone other than the participant's spouse, or a person listed as the participant's dependent for income tax purposes; or a participant's child under age 19.
- In a dependent care center or a child care center, which meets all applicable state and local regulations.
- By a housekeeper whose services include, in part, providing care for a qualifying individual.

To be eligible, a **dependent** must meet the following:

- Must be a child under the age of 13.
- Must be a spouse or qualified dependent that is physically or mentally unable to care for him or herself.
- Must be an elderly parent and qualify as an eligible dependent.

Note: Please refer to the **http://www.irs.gov/pub/irs-pdf/p503.pdf** IRS publication 503, "Child and Dependent Care Credit as a guide for covered and non-covered expenses.

(Do not fax or send this page)