How to Submit a Claim for Dependent Care Accounts

We offer two easy ways for you to access your Dependent Care Account funds. For fastest results, we encourage you to submit your claim online.

For Dependent Care Accounts, you may only receive reimbursements for expenses already incurred. An expense is incurred when a service is received, not when a bill is paid. Even though your service provider may require payment at the beginning of the service period, you cannot request reimbursement until after the service has been provided.

**Online Claim Submission**

1. Log into your online account at premera.com. Click on “Personal Funding Account,” under Manage My Account.
2. Click on the “Manage Your Account” box.
3. Click “Add New Claim” from the left-hand menu. Enter the requested information about your claim and continue through the screens to create the Claim Submission Form for that particular claim. Each Claim Submission Form has a unique bar code and should only be used to submit documentation for that claim number.
4. Print the Claim Submission Form and fax it, along with the required receipts and other documentation, to 866-741-0386.

**Paper Claim Submission**

1. If you are unable to access the Internet, complete the attached Dependent Care Account Claim Form.
2. Ask your provider to complete the Provider Information section on the form as documentation. Or, submit documentation from your dependent care provider containing the required information (Provider’s Name, Dependent’s Name, Service Period, Payment Amount and Care Being Provided).
3. Fax the form with receipts and other documentation to 866-741-0386. When you fax the form and supporting documentation, there is no need to follow up with a hard copy in the mail. Remember to keep the original claim form and supporting documents for your records.
4. If you choose to mail your form and documentation instead of faxing, the address is: Claims Department
   P.O. Box 622318
   Orlando, FL 32862-2318
Dependent Care Account Claim Form

Use this form to submit your claims for reimbursement of eligible dependent care expenses that have not already been submitted.

- Do not use this form if you already submitted this claim online.
- You may only receive reimbursements for expenses already incurred. An expense is incurred when a service is received, not when a bill is paid. Even though your service provider may require payment at the beginning of the service period, you cannot request reimbursement until after the service has been provided.
- Complete all entries on this submission form. Please print or type.
- Sign and date this form.
- Fax or mail it, along with the required documentation, to the claims department. (See submission instructions below).

### Personal Information

<table>
<thead>
<tr>
<th>Name of Employer</th>
<th>Employee Name (last name, first name)</th>
<th>Social Security Number</th>
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### Provider Certification or Documentation Required

You may either have your provider complete this section or you may submit documentation with this form. If submitting documentation, attach a copy of an itemized statement from your provider. The provider’s statement must include the provider’s tax ID, dates of service and amount charged. Cancelled checks, credit card receipts or balance forward statements are not sufficient documentation.

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Provider Address:</th>
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Provider Certifies: • I am a qualified care provider. • I provided care as noted above and charged the amount listed.

![Signature]

Provider Signature | Date
---|---

### Claim Details

<table>
<thead>
<tr>
<th>Service Start Date</th>
<th>Service End Date</th>
<th>Dependent’s Name</th>
<th>Relationship to Employee</th>
<th>Name of Provider</th>
<th>Description of Service</th>
<th>Amount Requested</th>
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### Authorization and Certification

*Read carefully: This claim will not be processed without your signature.*

I certify that these expenses have been incurred on behalf of my eligible dependent. The expenses have not been reimbursed and are not reimbursable under any other plan, such as my spouse’s or dependent’s plan. I understand that any amount reimbursed may not be used to claim any federal income tax deduction or credit on my or my spouse’s income tax return. I certify that the expenses are eligible expenses under the terms of the Dependent Care Assistance Plan document.

![Signature]

Employee Signature | Date
---|---

### Submission Instructions

For fastest results, fax to: 866-741-0386  
Or mail to: Claims Department  
P.O. Box 622318  
Orlando, FL 32862-2318

For funding account questions call 800-941-6121. For health plan questions call 800-722-1471.