INNOVA Benefit Services

CLAIM FORM:
Dependent Care Expenses

Participant Information (*Please Print*)

Employer Name:	
Employee Name:	Social Security Number:
Street Address:	City, State, Zip:
Email Address:	Daytime Phone:

Dependent Care Expenses (*Attach Supporting Documentation*)

Acceptable Documentation (must include ALL of the following information)

- Dependent's Name
- Date of Service
- Service Provider's Name
- Amount Charged

Unacceptable Documentation

- Credit Card Receipts
- Balance Forward / Previous Balance / Payment Statement
- Canceled Checks

Dependent's			Date of Service		Service Provider's Name	Amount to be Reimbursement
Name	Age	Date of Birth	Beginning	Ending		
					Total	$

Claim Certification (*Signature & Date Required*)

I certify that my qualified dependent(s)* have incurred eligible expenses for which reimbursement is sought under the Flexible Spending Account in which I have enrolled and that these expenses have been incurred during the plan year. I declare that I am requesting reimbursement for expenses that have not and will not be reimbursed under any other benefit plan or program and that I have not and will not claim these expenses as an income tax deduction. *See the Claim Form Instructions for the definition of a qualified dependent.

Signature:	Date:

Submit Your Completed Claim Form & Documentation (*Via one of the following methods*)

Fax: 877.774.1328

Upload: www.innovaben.com/Files Submission/Claims

Mail: INNOVA Benefit Services, Claims Department, 795 Pine Valley Drive, Suite 21, Pittsburgh, PA 15239

Did you know we also have an electronic "Online Claim Entry" option?

You can access the "Online Claim Entry" by logging into your online account.