

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.choice-strategies.com 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: 877-723-0148, US Mail: Choice Strategies, P.O. Box 2205, South Burlington, VT 05407
- **Claim processing time** - Claims will be processed within 2 business days after WageWorks receives the form. You may check the status of your claim by logging into your account at www.choice-strategies.com.



##14CHOICE#####

ACCOUNT HOLDER:

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Last Name

First Name

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Employer Name

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ID Code*

Zip Code

*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.

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												
Signature of Provider: (Replaces the need for other proof of service.) _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:5%;"> </td><td style="width:5%;"> </td><td style="width:5%;"> </td><td style="width:5%;"> </td><td style="width:5%;"> </td><td style="width:5%;"> </td></tr> <tr><td style="width:5%;"> </td><td style="width:5%;"> </td><td style="width:5%;"> </td><td style="width:5%;"> </td><td style="width:5%;"> </td><td style="width:5%;"> </td></tr> </table>													Dependent Name: _____ Relationship to Account Holder: <input type="radio"/> Spouse <input type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other _____ Type of Service: <input type="radio"/> Child Care <input type="radio"/> Preschool <input type="radio"/> Before/After school <input type="radio"/> Senior day care <input type="radio"/> Au pair <input type="radio"/> Summer day camp	\$ _____
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More expenses? Please complete another form.

CLAIM FORM TOTAL: \$ _____

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).