HealthEquity®

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Dependent Care Account
How to File a Claim for Approval

Claim Filing Options:

- **File claim online:** Log in to your account at **www.HealthEquity.com** to submit your claim electronically.
- **File claim via fax or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. **Fax:** 877-353-9236, **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

Instructions to fill out this form:

- Complete ALL account holder information. Please give your employer name without abbreviation.
- Use your documentation to complete each section of the form, including the following items:
  - **Provider Name**
  - **Service Date(s)**
  - **Dependent Name and Relationship to Account Holder**
  - **Type of Service**
  - **Amount Billed**
  - **Provider Signature is *not required*, but can replace need for other proof of service**

Tips For Claim Submission

- Dependent care expenses cannot be paid to anyone who is your child or stepchild under the age of 19 and claimed as a dependent on your tax returns.
- A dependent is defined as someone who spends at least 8 hours a day in your home and is one of the following:
  - **A tax dependent child for whom you have custody more than half of the year.**
  - **A dependent that is physically or mentally incapable of self care regardless of age.**
- Only submit claims for eligible expenses. Extended overnight camps, kindergarten or higher-grade tuition, non work-related day care or long-term care services are not eligible expenses. The only expenses considered eligible are those that are incurred while you or your spouse are working, looking for work, or attending school full time.

Tips For Documentation

- Ensure that the documentation is legible.
- Cancelled or copies of checks and credit card receipts do not contain all 5 required pieces of information needed to approve your expense, and are not acceptable for submission.
- If multiple pieces of documentation are attached, please circle the dollar amount that is being claimed on each piece of documentation.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- At the end of the tax year, you are required to provide the IRS with the provider name, address and Tax ID # on Tax Form 2441 in order to obtain the tax advantage for these expenses.

Tips For Faxing

- Do not use a cover page when faxing the claim form and documentation.
- Please allow 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file (to update your email address, please log in to your account at **www.HealthEquity.com**.
- Send only photocopies of your claim form and documentation—keep the originals for your records if submitting via postal mail.
- Submit only claims for your own account.

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Dependent Care Account

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.HealthEquity.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: 877-353-9236; **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- **Claim processing time:** Claims will be processed within 2 business days after receipt of the form. You may check the status of your claim by logging in to your account at **www.HealthEquity.com**.

ACCOUNT HOLDER:

Last Name

First Name

ID Code*

Account Holder 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.

Employer Name

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.)		**Dependent Name:** _____ **Relationship to Account Holder:** ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: _____ **Type of Service:** ☐ Child Care ☐ Preschool ☐ Before/After School ☐ Senior Day Care ☐ Au pair ☐ Summer Day Camp	$
Signature of Provider: (Replaces the need for other proof of service.)		**Dependent Name:** _____ **Relationship to Account Holder:** ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: _____ **Type of Service:** ☐ Child Care ☐ Preschool ☐ Before/After School ☐ Senior Day Care ☐ Au pair ☐ Summer Day Camp	$
Signature of Provider: (Replaces the need for other proof of service.)		**Dependent Name:** _____ **Relationship to Account Holder:** ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: _____ **Type of Service:** ☐ Child Care ☐ Preschool ☐ Before/After School ☐ Senior Day Care ☐ Au pair ☐ Summer Day Camp	$
Signature of Provider: (Replaces the need for other proof of service.)		**Dependent Name:** _____ **Relationship to Account Holder:** ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative ☐ Other: _____ **Type of Service:** ☐ Child Care ☐ Preschool ☐ Before/After School ☐ Senior Day Care ☐ Au pair ☐ Summer Day Camp	$

More expenses? Please complete another form.

CLAIM FORM TOTAL: $ 0

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.

By requesting reimbursement here, I confirm these services have already been provided and that I have not and will not seek reimbursement of this expense from any other plan or party. Use of the applicable service indicates my acceptance of the HealthEquity User Agreement at www.HealthEquity.com.

Optional provision: The Consolidated Appropriations Act (CAA) 2021, temporarily allows for an eligible employee to be reimbursed expenses for dependents through age 13 (i.e., dependents who have not yet turned 14) for the 2020 plan year. To qualify for this relief, you must have been enrolled on or before January 31, 2020 and you must have unused amounts from the 2020 plan year. In addition, you must have one or more dependents who attained the age of 13 during the 2020 plan year. You may also take advantage of this relief for the next plan year if unused grace period amounts from the 2020 plan year or other funds carried over into the 2021 plan year. Please refer to your plan documents to determine if this option is available under your plan.