SISC FLEX
Dependent Care Claim Form

Employee Information (Please print clearly)

Employer:			
Name:	First MI Last	**SS#:**	
E-mail Address		**Phone:**	( )

DEPENDENT CARE CLAIMS					
MM/DD/YR Date of Service From	**To**	**Dependent Name**	**Age**	**Dependent Care Provider Name**	**Claim Amount**
					$
					$
					$
					$
Care Provider's Tax ID#				**TOTAL**	$ 0.00

PLEASE ATTACH A RECEIPT OR ITEMIZED BILLING ***OR*** HAVE PROVIDER CERTIFY BELOW.

Provider's Certification:

Name of Care Provider _____ Tax ID #_____

Care Provider's Relation to Employee, if any_____

Address where services were performed: _____

Number of individuals cared for at this center: _____ Date Services Provided (MM/DD/YR) _____

If registration or enrollment fee, please include the school year that applies:_____

I certify that the above described dependent care expenses were incurred by the employee named above.

Care Provider's Signature _____ Date_____

Mail Claim Form and Supporting Documentation to:
SISC Flex, P.O. Box 1808, Bakersfield CA 93303-1808 ♦ Or FAX to (661) 636-4063

Eligible reimbursements will be paid by check and mailed to your home address, or directly deposited to your bank account when authorized. Please notify SISC Flex of any change in address as soon as possible.
Please retain a copy of the claim form and supporting documentation for your records.

Employee Certification for Reimbursement: I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. I agree to supply the taxpayer identification (Social Security) numbers of the care provider to the IRS on my tax return. Further, I understand that I have 90 days (run-out period) following the end of the plan year to file claims for the current year. Expenses for all claims must be incurred during the current plan year. If there is a question regarding eligibility of expenses or the dependency status, SISC Flex may require additional information. All claims and supporting documentation must be received by the SISC Flex office no later than March 31st.

Employee's Signature _____ **Date** _____

For SISC Flex Use Only

Authorization _____ Date _____ Claim # _____

Amount Approved _____ Amount Pending _____ Amount Denied_____

Explanation: _____

Rev. Sept. 2012

SISC Flex Health Care & Dependent Care Claim Filing Instructions

1. Health care expenses must be a qualified health care expense (e.g., medical, dental or vision deductibles, co-payments or other un-reimbursed expenses) incurred by you or one of your dependents, and not for general health or cosmetic purposes.

2. Dependent care expenses must satisfy IRS regulations.

3. Supporting documentation must accompany all Claim Forms for each expense submitted for reimbursement. Incomplete claim form or supporting documentation may delay processing or result in a denied claim.

4. You have 90 days (run-out period) following the end of the plan year to file claims for the current year. Expenses for Health Care claims must be incurred during the current plan year, or during the grace period (2 ½ months following the plan year-end) associated with that plan year. If there is a question regarding eligibility of expenses or the dependency status, SISC Flex may request additional information. All claims and supporting documentation must be received by the SISC Flex office no later than March 31st.

5. Complete the appropriate claim form and submit the original along with your supporting documentation to: **SISC Flex, P.O. Box 1808, Bakersfield CA 93303-1808, or FAX to (661) 636-4063**. Eligible reimbursements will be paid by check and mailed to your home address, or directly deposited to your bank account when authorized. Please notify SISC of any change in address as soon as possible. Please retain a copy of the claim form and supporting documentation for your records. Submitted information will not be returned.

Supporting documentation for Health Care expenses includes:

► For **prescription drugs**, attach a legible receipt from the service provider, which includes the: 1) Date prescription was purchased; 2) Drug name and prescription number, or the Rx label; 3) Amount of purchase; 4) Name of the pharmacy; and 5) Patient name. The Rx ticket typically contains all required information.

► For **medical, dental, vision and other health care expenses,** documentation must include a legible copy of the provider's itemized statement of the charges including: 1) Provider's name and address; 2) Date of service or purchase; 3) Description of service or product; 4) Amount charged for service or product; and 5) Patient name. A copy of the Explanation of Benefits (EOB) is acceptable and preferred. (Both primary and secondary EOB's if applicable.)

► For eligible **over-the-counter (OTC) expenses**, the item must be clearly defined on the receipt indicating: 1) Date of purchase; 2) Amount of purchase; 3) Name of the product; and 4) Merchant name and address. If the item is abbreviated on your receipt, you must attach a photocopy of the package label showing the full product description. OTC drugs and medicines must be prescribed.

► In some cases a Certification of Medical Necessity form may be required. The Internal Revenue Service (IRS) regulations specify that in order to reimburse products and/or services that may have both a medical purpose and a personal or general health purpose; we must require a medical practitioner's certification or letter. Some health care services and products are potentially eligible for reimbursement from your SISC Flex Health Care Expense Account when your medical practitioner certifies that they are medically necessary. Your provider must indicate your (or your spouse's or dependent's) specific medical condition, the specific treatment needed, and the duration of treatment. A Certification of Medical Necessity form is available on our website.

Supporting documentation for Dependent Care expenses includes:

► Services provided by a pre-school or day care center will require an invoice indicating providers name, address and taxpayer identification number (TIN) or Social Security Number, dates services were provided, incurred charges and payments, or completion of the provider's certification on the claim form.

► Services provided by a nurse's aid or individual will require a receipt of payment, indicating the provider's name, address and taxpayer identification number (TIN) or social security number, dates services were provided, incurred charges, and payments, or completion of the Provider's Certification on the claim form.

SISC Flex
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Website: http://sisc.kern.org/flex