BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

Request For Reimbursement Preferred Dependent Care Account

Attach a copy of the itemized bill along with proof of payment. All documentation must include the dependent name, description of service provided, date provided, and the charge. Be sure to sign and date this form before sending it with all attachments to the address shown.

Blue Cross and Blue Shield of Alabama
Benefits Service Center
P.O. Box 11586
Birmingham, Alabama 35202-1586
1 800 213-7930
Toll Free Fax 1 877 889-3610 • Birmingham Area Fax1 205 220-7991

Visit our web site **www.bcbsal.com** for detailed account information

EMPLOYEE INFORMATION

Employee Name (Please Print) Last First MI

Company Name

PREFERRED BLUE ACCOUNT NUMBER

Your Preferred Blue Account Number is your Blue Cross and Blue Shield of Alabama contract number. If you do not have your account number, please contact Customer Service.

Work Telephone (Please include Area Code)

Home Telephone (Please include Area Code)

DEPENDENT CARE REIMBURSEMENT INFORMATION

In order to be properly reimbursed, please complete this section for each eligible receipt. (Please attach all necessary receipts.)

	Name	Relationship	Date of Birth	Date of Service	Amount
1.		☐ Spouse ☐ Dependent*	MM / DD / YYYY	MM / DD / YYYY	
2.		☐ Spouse ☐ Dependent*			
3.		☐ Spouse ☐ Dependent*			
4.		☐ Spouse ☐ Dependent*			
5.		☐ Spouse ☐ Dependent*			
6.		☐ Spouse ☐ Dependent*			
				TOTAL	$ 0.00

For reimbursement for your Dependent Care Account, please provide the following information.

Provider of Care Name (Day Care, Elder Care etc.)

Provider of Care Social Security number or taxpayer I.D. number

I certify that the attached expenses are eligible for reimbursement from my designated Dependent Care Account and that they qualify as deductions as outlined by the Internal Revenue Code. I request reimbursement up to the limit allowed based on my election. I further certify that these expenses have not been reimbursed and are not reimbursable under any other benefit plan. Dependent must be considered an eligible dependent under the applicable provisions of the Internal Revenue Code.

SIGNATURE OF EMPLOYEE

DATE SIGNED

Important: This form is not used to reimburse you for your Blue Cross and Blue Shield of Alabama health benefits. It may only be used to request a payment from a tax-deferred, employee-funded spending account established by your employer under Section 125 of the U.S. Internal Revenue Code. Payments from such an account may only be made for qualified dependent care expenses on behalf of qualified dependents where such expenses have not been reimbursed and are not reimbursable by any other benefit plan.