BlueCross BlueShield of Vermont

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

DAYCARE EXPENSE REIMBURSEMENT CLAIM FORM

Use this form for dependent child or adult daycare expenses.

☐ ✔ if this includes documentation for previously denied claim

☐ ✔ if new email address ☐ ✔ if new address

Each field must be completed or the processing of your claim will be delayed or denied. See the reverse side for eligibility and submittal information.

Number of pages _____

Section A – Account Holder Information (Please Print)

ACCOUNT HOLDER'S NAME LAST	FIRST	MIDDLE	SPENDING ACCOUNT ID# S A
STREET ADDRESS			SOCIAL SECURITY # (if SA# not known)
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
ACCOUNT HOLDER EMAIL ADDRESS		EMPLOYER NAME	

Section B – Claim Detail (Please Print)

DEPENDENT(S) NAME(S)	TOTAL REIMBURSEMENT REQUESTED $
DATE(S) OF SERVICE OR DATE SPAN	

Section C – Daycare Provider Information

For fastest service, please have your provider complete this section. If completed, additional supporting documentation is NOT needed. For expenses to be eligible, this section must be completed and signed by the Provider of dependent care services or documentation must be attached from the Provider.

PROVIDER'S NAME	PROVIDER TAX ID OR SOCIAL SECURITY # (Optional)
PROVIDER'S SIGNATURE - This signature verifies that I am an eligible provider, the claim details above are accurate, and the account holder is being billed for these services.	__ __ __ __ __ __ __ __ __

Section D – Account Holder Signature

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.

ACCOUNT HOLDER SIGNATURE	DATE

Save time: submit this information online. Questions? Call Member Services at 1-866-999-2605.

Submit online:
Log into your account at bcbsvt.com/mymoney

Send via secured email only:
mymoneybcbsvt.documents@hellofurther.com

Fax to:
866-231-0214

Mail to:
PO Box 982814
El Paso, TX 79998-2814

How to File a Claim

For faster reimbursement, submit claim online at bcbsvt.com/mymoney.

Be sure to complete the form in it's entirety. If the form is incomplete or unsigned, your claim request will be delayed or denied. **Based on IRS regulations, supporting documentation is not required with your claim if Section C of the claim form is completed. Keep documentation for your tax records.**

If you cannot submit online, fax OR mail completed claim form.

You will be reimbursed up to your account balance for all eligible dependent care expenses according to your employer's claim processing schedule.

Withdrawals requested that exceed your account balance will be pended until eligible for reimbursement within the same plan year as incurred.

Submission Tips

✔ Complete claim form using a dark pen
✔ **Do not use a highlighter** on this claim form
✔ Retain confirmation of successful fax transmission
✔ Do not mail originals, keep a copy for your records or upload to our document storage found at **bcbsvt.com/mymoney**
✔ **To receive your reimbursement faster,** sign up for direct deposit by logging into your account at **bcbsvt.com/mymoney**.

Eligibility Information

- **Care must be for a child under age 13,** unless they are incapable of self care.
- If child is over 13 and incapable of self care, a yearly Letter of Medical Necessity is required and the form can be found at **bcbsvt.com/mymoney.**
- Care must be provided by an individual with a tax ID or Social Security Number
- Care must allow the parent(s) to be gainfully employed
- Care must be custodial in nature
- Household limit for dependent care reimbursement cannot exceed $5000 per year, including annual election, any child care subsidies that received, and/or amounts that your spouse has elected through another account.

Ineligible Services

- School expenses including kindergarten
- Overnight camp
- Care provided by a family member under the age of 19
- Care provided by a parent or family member that can be claimed as a tax dependent of the parent
- Activity fees/field trips
- Late payment fees
- Food items

Appeal Information

The Explanation of Processing Report explains how your claim was processed based upon the information submitted to us. You or your designated representative may appeal a denial, partial denial, or reduction of your claim by following our appeal procedures. You may contact customer service at 1-866-999-2605 for an explanation of your appeal rights. If you disagree with our decision on your claim, you have the right to submit a written request for an appeal review to BCBSVT MyMoney, PO Box 982814 El Paso, TX 79998-2814. We can send you a form to file your appeal or you can obtain a copy of the appeal form at bcbsvt.com/mymoney. You have until the later of your plan's run out end date or 180 days from the date of this notice to file an appeal. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or contact our customer service department. You may also submit any documents, records, or other information that relates to your claim for benefits. Upon receipt of your request, we will provide a full and fair review of your appeal and a written notice of our decision either by letter or an explanation on the Explanation of Processing Report within 30 days.

If you are a member of a group plan that is subject to the Employee Retirement Income Security Act (ERISA), once you have exhausted our appeal process, you have the right to file suit in Federal Court under Section 502(a) of ERISA.