HealthSmart Benefit Solutions
PO Box 16647, Lubbock, TX 79490-6647
P 844.516.3658 F 844.319.3669

Reimbursement Request Form

Dependent Care Account

☐ Check here if address has changed.

PART 1. EMPLOYEE INFORMATION (Please Print)

Name (Last, First, Middle Initial)	Date of Birth (mm/dd/yyyy)	SS # or Member ID
Address (Street, City, State, Zip)		
Email	Phone	Employer Name

PART 2. DEPENDENT CARE EXPENSES

Dependent Full Name & Date of Birth	Dates of Care		Provider Name	Reimbursement Amount Requested
	From	To		
				Total $

Provider Signature	Tax ID #:

PART 3. EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses requested from my reimbursement account were incurred by me (and/or my eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief are eligible for reimbursement. I will not use the expenses reimbursed as deductions or credits when filing my income tax return.

Any person who knowingly and with intent to injure, defraud, deceive, or files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Signature _____ Date _____

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Employee Instructions

Please read these instructions before completing the Reimbursement Request form.

Step 1	Complete all areas of Part 1: *Employee Information*.
Step 2	Complete all areas of Part 2: *Dependent Care Expenses*, for daycare or eldercare services. If the provider signs the claim form *and* includes the Tax ID number, documentation is not needed. Otherwise, please provide documentation which clearly states each of the following items: 1. Name of person receiving the care as well as their date of birth (dependent child must be under the age of 13 for the duration of the service). 2. Dates of when care was provided. 3. Name of person or organization providing the care. 4. Reimbursement amount. 5. The care provider's tax identification or social security number. Services that are primarily educational are *not eligible*.
Step 3	Read Part 3: *Employee's Certification for Reimbursement* statement. Sign, and date the form where indicated.
Step 4	There are four ways to submit your claim(s) to HealthSmart: **1) Self Service Portal:** https://healthsmart.wealthcareportal.com and login to the member's portal site. In order to submit your claim via HealthSmart's secure portal site, you will need your Member ID or Social Security number. If you do not have your User ID and password, contact Customer Service: 844.516.3658 **2) Mobile application**: HealthSmart My Flex Spending **3) Fax**: 844.319.3669 **4) US Mail**: P.O. Box 16647, Lubbock, TX 79490-6647