



DEPENDENT CARE SPENDING ACCOUNT RECEIPT

Amount: \$ _____

Dates of Service: From _____ / _____ / _____ to _____ / _____ / _____
month day year month day year

Name(s) of Dependent(s): _____

Service Provider Information:

Name of Provider: _____

Tax ID or SS#: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Child Care Provider's Signature

Date

The receipt must be attached to a Reimbursement Form or an Online Claim.