

Recurring Expense Service Form

INSTRUCTIONS: This form is used to request your Dependent Care Account. Contributions will be reimbursed to you on a per pay period basis. By completing this form you will not need to provide continuing documentation. Please complete all fields and include appropriate documentation stating your child will be attending throughout the year or specific time frames. **All information must be completed by you & your Dependent Care facility to receive reimbursement. CLAIMS WILL NOT BE PROCESSED WITHOUT YOUR SIGNATURE AND THE PROVIDER'S SIGNATURE.**

A. Declaration of Services

I request reimbursement for the below listed timeframe for qualified Dependent Care Services

I certify that the services will be provided between the following dates:

_____ to _____
Start Date of Services (MM/DD/YY) End Date of Services (MM/DD/YY)

I have included signed copies of the independent provider's charges, which will include the total amount of:

\$ _____ for the dates provided above.
Total Amount of Services

NOTE: If you have any changes during the dates referenced above, please notify:
DataPath Administrative Services, Inc. at (877) 685-0655 or email info@idpas.com.



B. Participant Information

Name of Participant	Social Security Number		
ADDRESS Street	City	State	Zip
Phone Number ()	E-Mail		
Name of Dependent			

C. Care Provider Information

Name of Dependent Care Provider			
ADDRESS Street	City	State	Zip
Federal Tax ID			

D. Signatures

 Authorized Signature of Provider	_____	_____	Date
 Participant Signature	_____	_____	Date

PLEASE NOTE: Your total reimbursement amount will be figured on the amount which you have elected for the year based on the amount of payrolls that occur throughout the plan year. For questions regarding your maximum contribution amount, please contact (877) 685-0655.

FOR FASTEST PROCESSING, FAX TO: (888) 472-6777 OR EMAIL: INFO@IDPAS.COM