877-248-0510 855-717-6571
PO Box 6161 | Fargo, ND 58108-6161
forms@serviceaccount.com

Aptia365

Dependent Care Verification Form

Please note that this form does not replace the need to submit a dependent care claim. Rather, it is intended to accompany your dependent care claim and serve as a substitute for the documentation required to substantiate that claim. No reimbursements will be made if this form is not uploaded to a claim or accompanied by the appropriate form.

This form is to be completed by your provider after dependent care expenses have been incurred and should be used in place of dependent care documentation. Attach this form to an online or debit card claim via your online account or to an Out-of-Pocket Reimbursement Request Form. If your cost of dependent care per month exceeds your monthly payroll deductions, you can fill out a Recurring Dependent Care Request Form at the beginning of the plan year and be reimbursed as your payroll deductions post to your account.

Step 1: Dependent Care Provider Information and Signature (to be completed by the provider)

I certify the information provided below is accurate. I understand the purpose of my signature on this form is to substantiate the name of the dependent care provider, the dates of service care is being provided and the dollar amount of the services. I agree to provide the necessary receipts for documenting the participant's incurred dependent care expenses if requested.

*=Required Fields

*Dependent(s) Name	*Date Range of Services (mm/dd/yy)	*Amount Charged	*Name of Provider	*Provider's Signature	*Print Signer's Name

Note: Dates provided must be within current plan year. Future dates should not be submitted. Please submit after all dates have been incurred.

Step 2: Participant Certification

To the best of my knowledge, the provided information is complete and accurate. I certify that my dependent care expenses are eligible as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that WEX Health, Inc., including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have either obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441 which I must attach to my federal income tax return. I should retain a copy of all submitted documentation in the event of an IRS audit.

By submitting this form I certify the above.

Step 3: Submit your form(s)

Upload this form to an online or debit card claim via your online account.