Dependent care reimbursement account (DCRA) reimbursement form

HealthEquity

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Claims**
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.999.7829

For faster processing, enter the claim and upload required documentation using the 'Claims & Payments' tab on the member portal.

Account holder information ☐ Change of address

Company name		Last 4 of SSN or HealthEquity account number (6 or 7 digits)	
PERFICIENT		8607670	
Last name	**First name**		**M.I.**
KONATAM	RAVINDHAR REDDY		
Street address	**City**	**State**	**ZIP**
1314 MARQUETTE AVE, 601	MINNEAPOLIS	MN	55403
Mailing address (if different from street address)	**City**	**State**	**ZIP**
Email address (required)	**Daytime phone**	**Work phone**	
RAVINDHAR.RDDY@GMAIL.COM	(612) 406-6767	( )	

Dependent care reimbursement information (Review payment options below before proceeding)

Please have your day care provider sign below in the 'Provider certification' section. If your provider does not sign in the 'Provider certification' section, you must attach a bill or receipt showing actual dates of service (not the date you paid the provider), cost and the care provider's tax ID or social security number.

Select option (This is required. If an option is not selected, your request may be denied.)

☑ **Annual:** Elect this option if your dependent care amount is the same each month. HealthEquity will send automatic payments for the remaining *plan year* as deposits are posted to your account and the dates of service pass. With this option, you will not need to submit a new form each month. Payments will continue unless you request they be discontinued. You will need to submit a new DCRA reimbursement form at the beginning of the new plan year.

☐ **Pay as-you-go:** Select this option if you are requesting a one-time reimbursement.

Date incurred*	Dependent's name	Dependent's date of birth*	Amount*
Begin date: 1/1/2019 End date: 1/15/2019	LIYA REDDY KONATAM	06/11/2014	$ 15,288
Service provider	**Tax ID or SSN**	**Reason**	
YWCA, DOWNTOWN, MINNEAPOLIS	41-0693891	☐ Before/after school program ☐ Day care ☐ Pre-K ☐ Other	
Date incurred* Begin date:__/__/__ End date:__/__/__	Dependent's name	Dependent's date of birth* __/__/__	Amount* $
Service provider	Tax ID or SSN	Reason ☐ Before/after school program ☐ Day care ☐ Pre-K ☐ Other	
Date incurred* Begin date:__/__/__ End date:__/__/__	Dependent's name	Dependent's date of birth* __/__/__	Amount* $
Service provider	Tax ID or SSN	Reason ☐ Before/after school program ☐ Day care ☐ Pre-K ☐ Other	
*Required fields.		**TOTAL REQUESTED:**	$

Provider certification

Provider certification: I certify that I am a qualified care provider as defined by the Internal Revenue Code and that the expenses for services claimed above have been provided. Provider signature is only required when an itemized receipt for services is not available.

Provider signature	Date
	1/18/19

Account holder certification

Certification: I request reimbursement for the qualified expenses listed above. I have attached appropriate receipts or third-party proof that I have incurred these expenses within the plan year and during the benefit period under this plan. If "No Receipt Provided" is checked, I certify that this service provider does not provide receipts, such as for payments made by token/ticket machine, meter, or cash box). I certify that I have not been reimbursed for these expenses by my insurance or any other source. I understand that I cannot claim these expenses on my income tax return.

Account holder signature	Date
	1/24/19

Reimbursement method

☐ **Option 1—Check**
This method is slower. Please allow 7–10 business days to receive your check. **A $2.00 fee will be deducted from your dependent care reimbursement account (DCRA).**

☑ **Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® HRA/FSA.**
Note: If an EFT is not on file, a check will be sent and a $2.00 fee may apply. Please allow 7-10 business days for the check to arrive.

☐ **Option 3—Transfer the funds to the following account.** (Email address is required for EFT)

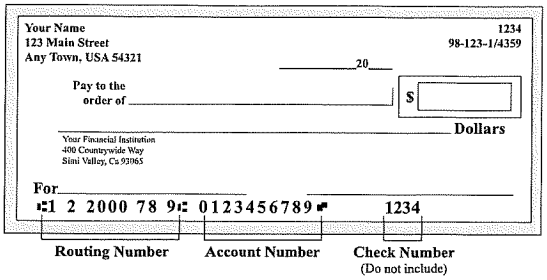
Account type: ☐ Checking ☐ Savings

Financial institution:_____

City/state:_____

Routing number:_____

Account number:_____



Form must be accompanied by a copy of a voided or actual check.

If you have additional expenses, please complete an additional form. **Send only copies of receipts.** Keep original receipts for your records.

If you have questions, contact HealthEquity® member services at 877.472.8632, they are available every hour of every day to assist you.