MedBen Group # ____________

DEPENDENT CARE RECEIPT FOR SERVICES FORM

Employee Name: ____SS#: _________________________

Address: ____

Instructions: This form may be used by a caregiver or provider of service as a receipt for dependent care services provided. Be sure to provide all information requested by this form. If the form is incomplete, it will be returned to you. Print or type the information requested. Then date and sign the form. **Send this form along with the Dependent Care Reimbursement Request Form to: MedBen, Specialty Services Unit, P. O. Box 1096, Newark, OH 43058-1096.**

Dependent Name: ____ Age________________

Dependent Name: ____ Age________________

Dependent Name: ____ Age________________

Dependent Name: ____ Age________________

Caregiver / Provider Name: ____

Address: ____

City, State, Zip: ____

Caregiver Tax ID Number or Social Security Number: ____

Date(s) services were provided: ______ / ______ / ______ to ______ / ______ / ______

Caregiver / Provider was paid the sum of $ _________________________ for the above date(s) of service.

____ ____________________________

Caregiver Signature Date

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or health care fraud under state and/or federal law. To report suspected fraud, call 1-877-9FRAUD 9 (1-877-937-2839).

Specialty Services Unit •1975 Tamarack Road • P.O. Box 1096 • Newark, OH 43056-1096
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