



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 qualified 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).