



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).