



DAY CARE REIMBURSEMENT REQUEST

(USE THIS FORM TO SUBMIT CLAIMS BY FAX OR MAIL)

(To send scanned claims go to: <https://secure.abpmtpa.com/flexupload>)

FAX: 406-523-3149 or **TOLL FREE FAX:** 877-424-3539

PHONE: 406-721-2222 or **TOLL FREE PHONE:** 877-424-3570

Please visit www.abpmtpa.com for additional forms.

Comment Box

Return FAX # _____

Return Phone # _____

PAGES: _____ including this cover sheet

Attention To:

Please use black or dark blue ink. Do not use highlighter, red ink or gel pens. DO NOT include medical, dental or vision expenses on this form.

Company: (Print) _____
(Required)

Employee Name: (Print) _____ SSN: _____
(Required) (Required)

Use one service line for each different provider. List the first name of each child in care, service dates and fees charged.
(Day Care expenses for children under 13; Adult daycare)

Day Care Name	Individual(s) in Care	Dates Incurred	Fees Charged	Provider Signature (If no receipt or bill attached)
_____	_____	___/___/___ to ___/___/___	\$ _____	_____
_____	_____	___/___/___ to ___/___/___	\$ _____	_____
_____	_____	___/___/___ to ___/___/___	\$ _____	_____
_____	_____	___/___/___ to ___/___/___	\$ _____	_____

IF YOUR PROVIDER DOES NOT SIGN THE CLAIM FORM YOU MUST SUBMIT INDEPENDENT, 3RD PARTY DOCUMENTATION OF THE EXPENSES WITH THIS CLAIM FORM. PLEASE ATTACH A STATEMENT OF YOUR ACCOUNT, A BILL OR A RECEIPT FROM YOUR PROVIDER.

I certify that the services described on this claim form were necessary for my employment or the employment or education of my spouse. The services were provided for my tax dependent child(ren) under the age of 13 years or any elderly/handicapped dependent. The dates and fees are true representations.

Employee Signature: _____
(Required)

Date: _____

Check here if your address has changed. Please list to the right.

New Address:

