DCAP Flexible Spending Account Claim Form

Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting receipts, vouchers, bills, etc.
- All receipts must detail each of the items summarized below
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to my.nbsbenefits.com
or call (855) 399-3035

Notice
All over-the-counter (OTC) medication claims must be accompanied by a prescription to be eligible under new federal regulations

1 Personal Information

Employee Name _____ Company Name _____

Street Address, City, State, Zip _____ ☐No ☐Yes Address Change?

Phone Number _____ Social Security Number _____

2 Dependent Care Expenses *(Dates of Service are required in order to process claim)*

Date of Service		Service Provider Tax ID# or SS#	Dependent's Name	Age	Amount
Start Date	End Date				
			Total Dependent Care Expenses		

3 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature _____ Date _____

Please fax, mail, or email your claim form and receipts to the following:
Mail: National Benefit Services, LLC, P.O. Box 6980, West Jordan, UT 84084
Fax: (844) 438-1496
Email: service@nbsbenefits.com (PDF, TIFF, or JPG files only)

Cafeteria Plan Dependent Care Receipt

Notice To Cafeteria Plan Participant

No payment may be made under the plan if the service provider is your dependent for federal income tax purpose, or is your child or stepchild and is under age 19. The Dependent you are claiming must be under age 13 or have qualifying restrictions.

This Form Must Be Submitted Along With A Dependent Care Claim Form

1 Personal Information

Participant Name

Dependent Name

Street Address, City, State, Zip

2 Dependent Care Expenses

Provider Name

Provider Social Security Number or Business ID Number

Provider Street Address, City, State, Zip

Provider Phone Number

$ Amount Received

From: To: Date of Service

Date(s) entered must be date(s) of service rather than the date the fee was paid. Please provide this information in order to avoid delay in the processing and reimbursement of your claim.

3 Provider Signature

Provider Signature

Date

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