Dependent Care Reimbursement Request

Employer

Plan Year

Employee Name

Employee Address

Employee Social No. | Employee Date of Birth | Employee Phone Number

Patient Name	Patient Date of Birth	Relationship to Employee	Date(s) of Service From	Date(s) of Service To	Description of Service(s)	Expenses

Total Expenses . . . . . .

Certification

I certify that I/we are providing the services for Dependent Care for the above employee on the dates listed.

Name of Provider:

Federal ID or SSN:

Signature of Provider: Date:

Signature of Employee: Date:

Administered by: Avalon Benefit Services
6543 Commerce Parkway, Suite M
P.O. Box 1803
Dublin, Ohio 43017
Phone: 800-820-4516 Fax: 614-793-9733 E-Mail: Staff@avalonbenefits.com