



DEPENDENT CARE CLAIM FORM

Employee Name _____ Banner ID _____
Address _____

A copy of the provider's bill and paid receipt MUST be attached

Provider Name _____

Address _____

Tax Identification Number _____

License Number _____

Dependent Name _____ Age _____
Relationship _____

Dependent Name _____ Age _____
Relationship _____

Dates of Service _____ to _____

Amount to be reimbursed _____

Employee Signature

Date