

Claim Filing Options:

- **File claim online:** Log in to your HealthEquity account at www.mylacountybenefits.com to submit your claim electronically.
- **File claim via fax or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation.
Fax: 877-353-9236, **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- **Questions?** Contact us at 877-924-3967. Representatives are available from 5am-5pm (Pacific time), Mon-Fri.

Instructions to fill out this form:

- Complete ALL account holder information. Please give your employer name without abbreviation.
- Use your documentation to complete each section of the form, including the following items:
 - ① Provider Name
 - ② Service Date(s)
 - ③ Dependent Name and Relationship to Account Holder
 - ④ Type of Service
 - ⑤ Amount Billed
 - ⑥ Provider Signature is not required, but can replace need for other proof of service

ACCOUNT HOLDER:		SERVICES		DEPENDENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE		OUT-OF-POCKET COST
S M I T H		J O H N		C O U N T Y O F L O S A N G E L E S		
5 4 2 1		1 0 0 6 3		John Smith		\$ 1 1 5 0 0
Sunshine Day School		0 1 0 2 2 1 0 1 0 6 2 1		<input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Qualifying Child <input type="checkbox"/> Qualifying Relative <input type="checkbox"/> Other:		
Debbie's Daycare		0 1 0 2 2 1 0 1 0 6 2 1		<input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Qualifying Child <input type="checkbox"/> Qualifying Relative <input type="checkbox"/> Other:		\$ 1 3 5 0 0

Tips For Claim Submission

- Dependent care expenses cannot be paid to anyone who is your child or stepchild under the age of 19 and claimed as a dependent on your tax returns.
- A dependent is defined as someone who spends at least 8 hours a day in your home and is one of the following:
 - A tax dependent child under the age of 13 for whom you have custody more than half of the year.
 - A dependent that is physically or mentally incapable of self care regardless of age.
- Only submit claims for eligible expenses. Extended overnight camps, kindergarten or higher grade tuition, non-work related day care or long-term care services are not eligible expenses. The only expenses considered eligible are those that are incurred while you or your spouse are working, looking for work, or attending school full time.

Tips For Documentation

- Ensure that the documentation is legible.
- Cancelled or copies of checks and credit card receipts do not contain all 5 required pieces of information needed to approve your expense, and are not acceptable for submission.
- If multiple pieces of documentation are attached, please circle the dollar amount that is being claimed on each piece of documentation.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- At the end of the tax year, you are required to provide the IRS with the provider name, address and Tax ID # on Tax Form 2441 in order to obtain the tax advantage for these expenses.

Tips For Faxing

- Do not use a cover page when faxing the claim form and documentation.
- Please allow 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file. (To update your email address, please log in to your account at www.mylacountybenefits.com and once in your HealthEquity account, select "Profile" in the upper right corner of the screen.)
- Send only photocopies of your claim form and documentation—keep the originals for your records if submitting via postal mail.
- Submit only claims for your own account.

- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log in to your HealthEquity account at www.mylacountybenefits.com to submit your claim electronically.
- **File claim via fax or mail:** Claim forms may also be filed either via fax or US Mail and sent to the following locations: **Fax:** 877-353-9236, **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- **Claim processing time:** Claims will be processed within 2 business days after receipt of the form. You may check the status of your claim by logging in to your account at www.mylacountybenefits.com.



ACCOUNT HOLDER:

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Last Name

First Name

C	O	U	N	T	Y	O	F	L	O	S	A	N	G	E	L	E	S
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Employer Name

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* ID Code is the last 4 digits of your Employee ID number assigned by your employer. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

ID Code*

Zip Code

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	DEPENDENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST								
Signature of Provider: (Replaces the need for other proof of service.)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30px; height: 30px;"></td> <td style="width:30px; height: 30px;"></td> <td style="width:30px; height: 30px;"></td> <td style="width:30px; height: 30px;"></td> </tr> </table>					Dependent Name: _____ Relationship to Account Holder: <input type="checkbox"/> Spouse <input type="checkbox"/> Qualifying Child <input type="checkbox"/> Qualifying Relative <input type="checkbox"/> Other: _____ Type of Service: <input type="checkbox"/> Child Care <input type="checkbox"/> Preschool <input type="checkbox"/> Before/After School <input type="checkbox"/> Senior Day Care <input type="checkbox"/> Au pair <input type="checkbox"/> Summer Day Camp	\$ <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30px; height: 30px;"></td> <td style="width:30px; height: 30px;"></td> <td style="width:30px; height: 30px;"></td> <td style="width:30px; height: 30px;"></td> </tr> </table>				
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More expenses? Please complete another form.			CLAIM FORM TOTAL: \$ <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30px; height: 30px;"></td> <td style="width:30px; height: 30px;"></td> <td style="width:30px; height: 30px;"></td> <td style="width:30px; height: 30px;"></td> </tr> </table>								

CERTIFICATION AND AUTHORIZATION: I certify that the information on this page is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by an eligible dependent (for a child under the age of 13 or other dependents that are physically and mentally incapable of taking care of themselves) while I was a participant in the plan. These services have already been provided and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. Use of this service indicates my acceptance of the User Agreement available in your HealthEquity account under Help, then select Terms of Use on the left.