MEDICA ONESource℠

Recurring Dependent Care Request Form

This form is to be completed each plan year and as changes occur when the participant wants to receive recurring reimbursement of dependent care expenses. Reimbursements will not be made prior to when the dependent care services are provided. Documentation must be retained for your records and provided to Medica when requested to do so. Receipts can be uploaded through the Member portal or faxed to (844) 730-0715. If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

Step 1: Member Information

*Required Fields

*Member Name (First, MI, Last)

*Employer Name

/ /
*Birth Date (MM/DD/YYYY)

- -
*Social Security Number

( ) -
*Day Telephone

Step 2: Auto-Dependent Care (DCA) Information

2a) Recurrence Status

*Please select only **one** to start, change, or stop reimbursement.*

☐	**Start Recurring DCA:** Please begin recurring reimbursement of my dependent care expenses. I understand Medica will request receipts as proof that expenses have been incurred.	**Effective Date (mm/dd/yyyy)**
☐	**Change Recurring DCA Information:** Please update my recurring reimbursement information with the provided information effective by the date specified in box A.	**A.**
☐	**Stop Recurring DCA:** Please stop recurring reimbursement of my dependent care expenses effective by the date specified in box B.	**B.**

2b) Dependent's Information

*Dependent(s) Name(s)	*Dependent's Social Security Number	* Dependent's Date of Birth *(mm/dd/yyyy)*	*Start Date of Service *(Must be within current plan year)*	*End date of Service *(Must be within current plan year)*	*Service Type *(Choose One)*
					☐ Child Care ☐ Adult Care**
					☐ Child Care ☐ Adult Care**

**If choosing Adult Care as the Service Type, you must provide a letter from a doctor or a Medical Necessity Form that identifies that the dependent is physically or mentally disabled and unable to self-care.

Step 3: Dependent Care Provider Information and Signature (to be completed by the provider)

I certify the information provided below is accurate. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

*Provider's Name

$ ☐ per month ☐ week
*Cost per month/week (circle one)

*Provider's Signature

*Provider's Name

$ ☐ per month ☐ week
*Cost per month/week (circle one)

*Provider's Signature

Step 4: Member Certification

To the best of my knowledge, the information provided is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Medica, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN), and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Medica. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

By submitting this form I certify the above.

*Member Signature

*Date

Return the completed form to: Medica ONESource, P.O. Box 2804, Fargo, ND 58108-2804. You may also fax (844) 730-0715.
Please call Member Services at (800) 918-6152 with questions.