# Recurring Service Claim Form (DCA)

This form is used to request ongoing reimbursement from your Dependent Core Assistance Pion (DCA) account. Contributions will be reimbursed to you on o per–pay–period basis. By completing this form you will not need to provide continuing documentation. Please complete all fields and include appropriate documentation stating your child will be attending throughout the year or during specific time fro mes. All information must be completed by you and your dependent core facility to receive reimbursement.
**CLAIMS WILL NOT BE PROCESSED WITHOUT YOUR SIGNATURE AND THE PROVIDER'S SIGNATURE.**

**A. Declaration of Services**

I request reimbursement for the below listed time frame for qualified dependent care services. I certify that the services will be provided between the following dates:
Start Date (mm/dd/yyyy) ______________________ End Date __________________________

I have included signed copies of the independent provider's charges, in the total amount of$ __________ for the dates indicated above.

**NOTE: If you have any changes during the dates referenced above, please notify TPA immediately.**

**B. Participant Information**

Employer Name {Please Print) ________________________________________________________________________________

Participant Last Name _____________ First Name ___________ Middle Initial _________________________________

Address ______________________________________________________________City __________ State ___ Zip _________

Social Security Number ___________Home Phone (__)_______Work Phone (___)_______Participant Email_________________

Name(s) of Dependent(s) _____________________________________________________________________________________

**C. Care Provider Information**

Name of Care Provider ________________________________________________________________________________________

Address ________________________________________City __________ State ___ Zip ____ Federal Tax ID Number ____________

**D. Signature**

Authorized Provider Signature ________________________________________________________ Date _____ / _____ / 
mm/dd/yy

Participant Signature ___________________________________________________________________ Date _____ / ____ / ______
mm/dd/yy

NOTE: Your total reimbursement amount will be figured on the total annual amount you have elected, based on the number of payrolls that occur throughout the plan year. For questions regarding your maximum contribution amount, please contact customer service.

**Submit completed form to:**

3817 Northwest Expressway, Suite 810,
Oklahoma City, OK 73112
(800) 850-7166 Fax: (405) 775-5992 Email: claims@abadmin.com

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