Request for reimbursement

DCAP Claim Form

Employer Name_____

Employee Last Name (Please Print)_____First Name_____Middle Initial _____

Address_____City_____State_____Zip_____

Social Security Number_____Home Phone (____) _____Work Phone (____) _____

Employee E-mail Address (if any)_____

Be sure to provide all information requested in each row as outlined in the 1st row, which is an example. If the form is incomplete, it will be returned to you. You can send this form along with the third-party documentation substantiating your claim(s) to OCA, 3705 Quakerbridge Road, Suite 216, Mercerville, NJ 08619, or by email at claims@oca125.com, or fax directly to 609-514-0111, 609-514-2778 (Alternate), 609-570-8980 (Alternate).

Dependent Care Claims

Service Period From	Service Period To	Dependent Name	Age	Provider Name	Service Description (DCAP)	Provider Tax ID#/SS#	Amount
02/01/25	02/28/25	John Smith	11	ABC Day Care	DCAP	123456789	$100
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
						Total	$

Provider's Certification **(If the provider signature certification is provided, employees are not required to submit supporting documentation)**:
I certify that I am the above mentioned provider or an authorized representative of the above mentioned provider. I further certify that the services specifically described above were provided by the provider for the above named dependent during the service period specifically described above. NOTE: Do not complete this section if you are not the above mentioned provider or the services described above were not provided (or the participant has not completed the section above).

Provider Name_____ Provider Signature: _____

Date: _____ Providers Tax ID: _____

Employee's Certification:

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependent(s), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plan. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature:_____**Date:**_____/_____/_____
mm/dd/yy