Dependent Care Spending Account
Reimbursement Form

Employer Name _____

Employee Name _____

Employee SSN _____

Address _____

City, State, Zip _____

Phone Number _____

Email _____

Child(ren) Name(s) _____

Date(s) of Service _____

Charge(s) _____

Name of Facility/Provider _____

Address of Facility/Provider _____

Provider's Tax ID or SSN _____

Signature of Provider _____

The dependent care expenses hereby presented for reimbursement from the Plan have not been reimbursed and will not be reimbursed through any other dependent care plan, including other dependent care flexible spending account arrangements. **Claim submissions are for qualified incurred services, per IRS regulations, future dates of reimbursement are not allowable and therefore will be denied.** If denied, the claim will need to be resubmitted once the services have been provided. If you have questions, email flexsupport@higginbotham.net

If you are not set up for direct deposit payments:

- Register for the web portal at flexservices.higginbotham.net
- From the consumer portal, click on Accounts tab, then under Profile click on Banking/Cards to enter your bank information. You may be required to complete a micro-deposit with your bank and will receive a message when completing the bank account set up if this is required. This process must be completed within a few days.

Employee Signature _____ Date _____

Mail, fax or email to: Higginbotham Attn: CDHP Department
500 West 13th Street, Fort Worth, TX 76102
Phone: 866-419-3519
Fax: 817-882-9267
Toll Free Fax: 866-419-3516
Email: flexclaims@higginbotham.net

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