BAYSTATE BENEFIT SERVICES

Employer Name: _____

Employee Name: _____

Dependent Care Receipt

You must also complete a Dependent Care Assistance Reimbursement Form.

Dependent Care Services have been provided as detailed below:

Dependent Name	Period: From - To (Days/Week/Month)	Cost

Dependent Care Provider: I hereby certify the above dependent care information is accurate.

_____ _____

Provider Signature Date

_____ _____

Facility/Provider Name TAX ID or SSN

Baystate Benefit Services, 400 Washington Street, Suite 400, Braintree, MA 02184
Tel. # (800) 601-3570 Fax # (781) 356-7365 Email 125@baystatebenefits.com