DEPENDENT CARE RECEIPT for FLEX PLAN REIMBURSEMENT
ECEIVED PAYMENT FROM (Parent/Guardian Name):
HILD(REN) NAME:
ATES OF SERVICE: TO Month/Day/Year Month/Day/Year
IARGES: \$
AYCARE PROVIDER SIGNATURE (Required as proof of payment):
AYCARE PROVIDER SOCIAL SECURITY OR TAX ID NUMBER:
DEPENDENT CARE RECEIPT for FLEX PLAN REIMBURSEMENT
ECEIVED PAYMENT FROM (Parent/Guardian Name):
HILD(REN) NAME:
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