BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

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PROVIDER'S STATEMENT OF QUALIFIED DEPENDENT CARE SERVICES ON CONTRACTUAL OR CONSTANT EXPENSE BASIS

____ HEREBY CERTIFIES THAT THE EXPENSES DESCRIBED
(provider's name)
BELOW FOR QUALIFIED DEPENDENT CARE SERVICES WILL BE INCURRED BY THE CLAIMANT PURSUANT TO A CONTRACT OR FOR THE CONSTANT AND CONTINUOUS AMOUNT STATED HEREIN.

1. NAME OF DEPENDENT(S) FOR WHOM CARE IS PROVIDED:

   ____

2. PERIOD OVER WHICH EXPENSES ARE TO BE INCURRED: ____________________

   THROUGH ____

3. AMOUNT TO BE INCURRED: $____________ PER PLAN YEAR.

I CERTIFY THE ABOVE INFORMATION TO BE TRUE AND CORRECT.

SIGNED: ____________________ DATE: ____________________
(provider or representative)

PROVIDER'S TAX I.D.# OR S.S.# ____________________

CLAIMANT'S STATEMENT

I UNDERSTAND THAT THIS CERTIFICATION IS SUBMITTED TO VERIFY CERTAIN EXPENSES INCURRED BY ME FOR REIMBURSEMENT UNDER MY EMPLOYER'S DEPENDENT CARE SPENDING ACCOUNT PLAN. I AGREE TO NOTIFY MY EMPLOYER IMMEDIATELY OF ANY CHANGE OR MODIFICATION OF ANY OF THE INFORMATION CONTAINED HEREIN.

EMPLOYEE NAME (PRINT): ____________________

SIGNED: ____________________ DATE: ____________________
(claimant)

CLAIMANT'S SOCIAL SECURITY # ____________________

EMPLOYER NAME: ____

 Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company