CBS Administrators
P.O. Box 36
Jamestown, Ca 95327
408.915.2280
csamuels@cbsadmin.com

DEPENDENT CARE EXPENSE VERIFICATION

_____ has been under my care for the period

covered from _____ to _____

and payment has been made to me in the amount of $_____ for these services.

PROVIDER INFORMATION

Name: _____

Address: _____

City/State/Zip: _____

Social Security Number / Tax ID Number: _____

Date: _____

Signature: _____

Please return this form with your claim for reimbursement to the above address.