PO Box 4346, Missoula, MT 59806
Phone: (877) 778-8600
Fax: (877) 424-3539
https://www.askallegiance.com/

DAY CARE REIMBURSEMENT CONTRACT

You may use this form for automatic reimbursement each month if you are required to pay monthly amounts even when you do not require care due to illness, vacation, etc.

Instructions

1. Please fill in all fields legibly. Missing information could cause a delay in processing.
2. Check the box below* to start a recurring claim or to change or stop an existing claim.
3. It is your responsibility to notify Allegiance of any changes in a timely manner.
4. You can fax your completed form to 1-877-424-3539.

Employer:	Date:
Employee Name:	Participant ID #:

□ Start*	□ Change*	□ Stop*

Dates rates are effective _____/_____/_____ to _____/_____/_____

The provider charges $_____ per month.

Dependent(s) for whom care will be provided:	
Provider's Name	Provider's Signature
Provider's Tax I.D. Number	

Some examples of **ELIGIBLE** expenses:	Some examples of **INELIGIBLE** expense:
• Day Care Centers • Elder Care • Family Child Care • Day Camps • Preschool • After School Care • Nanny / Au Pair	• Meals • Overnight Camps • Diapers • Education expenses, including Kindergarten • Incidental fees, such as activity fees and field trips

Claims are paid with the funds available in your account at the time your payment comes due. Unpaid balances continue to be paid as funds become available.

I certify that stated payment amounts are due provider even if absences occur during any billing period.

Employee Signature _____ **Date** _____