PAYMENT RECEIPT

All claims must be submitted within 30 days of care taking place Today's date:

# PROVIDER INFORMATION

Provider/business name

Street address

City State Zipcode

Phone number

# SERVICE DETAIL

Name of benefit holder

Child name(s)/Age(s)

Service description:

Service Rate

Per hour

Per day

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DATES OF CARE** | **HOURS OF CARE (REQUIRED)** | | **HOURLY RATE** | **TOTAL RATE** |
| **Start time** | **End t ime** |
|  |  |  | **$** | **$** |
|  |  |  | **$** | **$** |
|  |  |  | **$** | **$** |
|  |  |  | **$** | **$** |
|  |  |  | **$** | **$** |

TOTAL $

I certify that the information above, including dates of care and payment received by my employer is true. I also understand that I may be contacted by a representative of Care@Work to verify care.

Provider signature Date