



P.O. Box 246
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800-969-2009
Fax: 401-427-8701
www.AvantServe.com

Employee Information

Name:	Date:	Transmittal #:
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Dependent Care Claim Substantiation Statement

I hereby substantiate the claims attributable to the service(s) I/we provided listed above.

Provider Name: _____ Provider Tax I.D. No. _____

Provider Address: _____

Provider Signature: _____

Date: _____

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