# 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 time | | |
| | | | $ | $ |
| | | | $ | $ |
| | | | $ | $ |
| | | | $ | $ |
| | | | $ | $ |

**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**