THIRD-PARTY RECEIPT FORM

*Please fill out this form if you have been asked to provide a third-party receipt via email of transactions made by your Smartflex Card.

PLEASE MAIL/FAX/EMAIL TO: F.C.F. Benefits & Administration
5295 South 300 West Ste - 230
Murray, UT 84107
Fax - (801) 268.4590 or 1.800.748.4597
Email - ron@fcfinc.com

SMARTFLEX CARD RECEIPTS

(MEDICAL EXPENSES THAT HAVE BEEN PAID FOR WITH YOUR SMARTFLEX CARD)

Instructions: Fill in the necessary information below for the medical expenses incurred with your Smartflex Card. An original receipt showing date of expense or an explanation of benefits from your insurance carrier must accompany each expense item. **Each receipt must show the original date of service and the type of service provided.** Please keep a copy of each receipt for your records.

Date Expense Incurred	**Service Provider (i.e. Clinic, Doctor, Pharmacy, Store, etc.)**	**Description of Expense**	**Amount Paid Total Expense**	**Amount Paid By insurance (if any)**	**Amount Paid By you**

Total of Smartflex Card Receipts $_____

_____
Company Name

_____ _____ _____
SIGNATURE OF EMPLOYEE Date Social Security Number

_____ _(_____)_____
Please Print Name Day Time Phone Number

Have You Changed Your Address?_____
Number/Street City State Zip