



## Your Flexible Benefits Organization

### DAYCARE PROVIDER RECEIPT

Please submit this completed form along with your claim form by mail or by fax to:

**Send by Fax:**

**Fax: (877) 303 – 0742**

**Mail To:**

**The 125Company, Inc.**

**Flex Claims Group**

**P.O. Box 2401 Germantown, MD 20875**

#### Demographic Information:

**Employer Name:**

**Employee Name:**

**Social Security Number:**

**Email:**

**Phone#:**

**Provider Name:**

**Provider EIN# or SSN:**

**Provider Address:**

**City:**

**State:**

**Zip:**

#### Day Care Services:

**Dependent Name:**

**Date of Birth:**

**Age:**

**Date of Services:**

**Amount Paid: \$**

**Provider Signature:**

**Dependent Name:**

**Date of Birth:**

**Age:**

**Date of Services:**

**Amount Paid: \$**

**Provider Signature:**

**Dependent Name:**

**Date of Birth:**

**Age:**

**Date of Services:**

**Amount Paid: \$**

**Provider Signature:**

**Dependent Name:**

**Date of Birth:**

**Age:**

**Date of Services:**

**Amount Paid: \$**

**Provider Signature:**

**Employee Signature:**

**Date:**