125 Company	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:**	