



# SMARTFLEX® DEBIT CARD RECEIPT FORM



Instructions:

- \*Complete **all applicable** spaces on the form.
- \*Attach appropriate bills and forward to Tucker Administrators, Inc.
- \*All documentation must include original dates of service.
- \*Make a copy for your records

## DEBIT CARD ACTIVITY ONLY

Employer \_\_\_\_\_ Group / Division Number \_\_\_\_\_ Date \_\_\_\_\_

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Address \_\_\_\_\_

Email Address: \_\_\_\_\_

Medical Related Expense for: Patient Name \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medical Related Expense Amount: \$ \_\_\_\_\_ . \_\_\_\_\_ SmartFlex® Card Number: \_\_\_\_\_

**If faxed please provide a day time phone number for possible questions about your claim:** \_\_\_\_\_

To the best of my knowledge and belief, my statements in the Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Flexible Compensation Account be reduced by the amount requested.

**Employees Signature** \_\_\_\_\_ **Date** \_\_\_\_\_