



**SmartFlex™ Debit Card  
RECEIPT SUBMISSION FORM**

**TO:** First Financial Administrators, Inc.

**ATTN:** Flex Department

**FAX #** (800) 298-7785

**US MAIL:** P.O. Box 670329  
Houston, TX 77267-0329

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**Full Name (Please Print)**

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**Social Security Number**

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**Employer**

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**SmartFlex™ Debit Card Number**

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**E-Mail Address**

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**Home #**

**Work #**

Attach copies of your receipts with this cover sheet.  
Please keep copies of all original receipts for your records.

**Please submit this form with all SmartFlex™ Debit Card receipts. All submissions must include the name of the provider, description of service, date of service, name of patient, and amount charged. Credit card receipts are not acceptable proof of expense.**

**Do not use this form when submitting manual claims.**

**For questions, please call (866) 853-FLEX (3539)**