CARD TRANSACTION RECEIPT COVERSHEET

PLEASE USE THIS COVERSHEET ONLY IF YOU ARE FAXING/MAILING REQUESTED MASTERCARD/VISA DEBIT CARD RECEIPTS!
(You do not need to include this cover sheet if you are faxing a paper claim form with your receipts.)

SUBJECT: *Flex Convenience*® Card Transaction
FAX TO: Medical Group Insurance Services, Inc.
CLAIMS FAX #: 866.969.4446
MAIL TO: Medical Group Insurance Services, Inc.
PO Box 16110
Salt Lake City, UT 84116-0110
CUSTOMER SERVICE: 866.937.3539

FULL NAME ______________________________________ SSN _____ - _____ - ________
LAST, FIRST MI

DAYTIME PHONE (______) ______ - _______ E-MAIL ADDRESS ______________________________

EMPLOYER NAME ___________________________

Attach copies of your itemized receipts and/or explanation of benefits with this coversheet. Cancelled checks and/or credit card receipts are not sufficient to substantiate charges. MGIS will receive your fax and secure the content according to HIPAA Privacy requirements. Be certain you or others on your behalf secure your data at the point of origination. Original receipts WILL NOT be returned (Be sure to keep a copy of each of your original receipts).

NOTE: The customer is responsible for misrepresentation regarding requests for reimbursement. If you have any further questions, please contact customer service.

DATE AND INCURRED COSTS

DATED EXPENSE INCURRED (MM/DD/YY)	SERVICE PROVIDER (clinic, pharmacy, doctor, store, etc.)	RELATION TO PARTICIPANT	AMOUNT
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
		TOTAL AMOUNT OF ATTACHED RECEIPTS	**$**

I certify that I am authorized to use the debit card issued and that by signing and using the debit card, I agree to all terms and conditions. I understand that any transactions initiated by my use of an authorized Card are subject to the terms and conditions of the Cardholder Agreement received with the Card. I certify that the qualified healthcare expenditures presented with this transmittal have been received by an eligible individual and are true and accurate. I further certify that these expenses have not, nor will be, reimbursed through insurance or any other arrangement.

PARTICIPANT'S SIGNATURE X____ DATE / /