Diversified Administration, Inc.
Tax Savings For Employers & Employees

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Hollywood, FL 33024
Phone: 954-983-9970

Flexible Spending Account - FSA Ready Receipt

Participant Information

Employer Name:_____

First Name:_____ Last Name:_____ Last 4 of SSN:_____

Service Provider Information

Please have your care provider complete all sections in this form to ensure reimbursement of your expenses through your Section 125 Plan. The IRS requires the information below to process any expense for reimbursement through the plan.

Name of Service Provider:_____

Address of Service Provider:_____

Tax ID (or SSN) of Service Provider (for Child Care Only):_____

Person for whom the expense was incurred:_____

Relationship to Employee:_____

Expense Information

Type of Service Provided	Date Service Was Provided	Cost of Service Provided
_____	____/____/____	$_____.____
_____	____/____/____	$_____.____
_____	____/____/____	$_____.____
_____	____/____/____	$_____.____
_____	____/____/____	$_____.____

Signature of Provider:_____

Please send this receipt with a completed and signed claim form to:
Fax to (954) 983-9695 Or E-mail to claims@div125.com