COPAYMENT RECEIPT

Please use this form to assist in the process of obtaining substantiation for a copayment expense. This form must be completed fully to ensure all necessary information is obtained to substantiate your claim.

Should you have any questions please contact our customer service department: 603-647-1147.

Employee Name: ___________________________________ Email Address:_____________________________________

Mailing Address: __________________________________ City: ___________________ State: _______ Zip: _________

Telephone: _______________________________ Employer Name: ______________________________________

Copayment Details

Date of Service	Name of Provider	Type of Copayment	Copayment Amount

Total of Copayment Amount: $_______________

Provider's Office Signature: ____ **Date:** _______________________

Phone: 603-647-1147 • Fax: 1-866-978-7868 • email: info@hrcts.com • www.HRCTS.com • 111 Charles Street • Manchester, NH 03101