Orthodontic Schedule Form

An orthodontic treatment program usually spans more than one plan year, and therefore the entire amount cannot be reimbursed "up front". Only the portion which applies to your current plan year may be reimbursed (this includes a down payment, if applicable). You may be reimbursed for monthly amounts for the remainder of the treatment period, as they occur, but not for future dates of service.

Orthodontic Expenses
(Please attach supporting documentation and letter of medical necessity from Orthodontist)

Patient Name:		
Participant Name		
Participant SSN:		
Employer Group:		
Ortho Start Date:		
A. Total Treatment Fee:		
B. Down Payment/Initial Fee:		Maximum 20% of Total Fee
C. Insurance Portion / Payment: (if applicable)		
D. Remaining Balance:		A minus B minus C
E. Length of Treatment in Months:		
F. Monthly Reimbursement Amount:		D divided by E

I certify that our office will provide Orthodontia care as described above and that the above treatment is medically necessary.

Orthodontic Provider Signature __________ **Date** __________

READ CAREFULLY
The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and were incurred while I was covered under the Flexible Spending Account(s).

Flex Participant Signature __________ **Date** __________