MedBen Group # _____

HEALTH FSA – ORTHODONTIA SERVICES REIMBURSEMENT REQUEST FORM

Employee Name: _____ PID#:_____

Address:_____

Instructions: This form must be completed to receive reimbursement for orthodontic care. Be sure to provide all information requested by this form. If the form is incomplete, it will be returned to you. Print or type the information requested. Then date and sign the form. **Send this form to: MedBen, Specialty Services Unit, 1975 Tamarack Rd., P.O. Box 1096, Newark, OH 43058-1096.**

Patient's Name: _____

Orthodontist's / Provider's Name:_____

Address:_____

City, State, Zip:_____

Orthodontist's / Provider's Signature:_____

BREAKOUT OF CHARGES

Total Charges	$ _____	Orthodontic Care Start Date: _____ / _____ / _____
Minus Insurance	– $ _____	Estimated length of treatment: _____ months
Patient's Responsibility	= $ _____	Patient balance divided by estimated length of treatment:
Patient's Down Payment	– $ _____	$ _____ / _____ = $ _____ monthly*
Patient Balance	= $ _____	
Discount*	- $ _____	Discount* if Patient's Responsibility is paid up front _____
New Patient's Balance	= $ _____	* if applicable

AMOUNT OF REIMBURSEMENT BEING REQUESTED

(Please check ONE option only)

_____Monthly* payment _____ Total Patient Responsibility _____Down Payment _____ other: _____

* If monthly payment is selected - a claim will be added the 1st day of each month for the number of months indicated above (related to current plan year only)

To the best of my knowledge and belief, my statement in this Reimbursement Request Form is complete and true. I certify that I or my family member has received the services described above on the dates indicated, that the expenses qualify as valid medical services under the Plan, and that I have not been reimbursed previously under the Employers Plan or any other Health plan, FSA plan or HRA plan, nor do I expect any of these expenses to be reimbursable elsewhere. If the reimbursement is for prescription drugs, I certify that such drugs are not prescribed for cosmetic purposes. I understand that these expenses may not be used to claim any Federal income tax deduction or credit.

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or health care fraud under state and/or federal law. To report suspected fraud, call 1-877-9FRAUD 9 (1-877-937-2839).

_____ _____

Employee's Signature Date