



**ORTHODONTIA AUTOMATIC MONTHLY REIMBURSEMENT CLAIM FORM
FOR FLEXIBLE SPENDING ACCOUNT**

Please Print

Employer _____

Employee's Name _____ ID # _____

Patient's Name _____

My address has changed. My new address is _____

Orthodontic Expenses

Orthodontic expenses covered under an insurance plan must be submitted to the insurance carrier first.

In order to process your claim we must receive proper documentation. **To process your expense(s) we must receive a copy of the contract/treatment plan that you obtain from your orthodontist.** The treatment plan should include: the total cost of the treatment, estimated number months of treatment and the date the services began (date bands were placed). You must also include information indicating the amounts that will be paid by any insurance plan toward the expenses. Balance due statements and canceled checks are not acceptable.

This entire form must be completed in order for us to process your claim. Please check the appropriate box, complete the rest of the form and send to: Sheffield, Olson & McQueen at the address shown above.

I certify that the charges I am submitting are not covered under any insurance plan or policy.

or

I have attached information outlining the orthodontic coverage under any applicable insurance plan.

I hereby certify that the information shown above is true and correct, and that neither I, my spouse, nor any of my eligible dependents have or will receive reimbursement for any of the expenses listed above from any other source, and furthermore, that I have not, and will not, claim any of these expenses as a deduction on, or in calculating a credit for, my/my spouse's income taxes. In addition, I certify that the "Person Receiving Service" listed above is eligible to be covered under the Plan.

Signature _____ Date _____

3/29/2007