



WRIGHT STATE UNIVERSITY

FLEXIBLE SPENDING ACCOUNT ORTHODONTIC CLAIM FORM

EMPLOYEE INFORMATION *(Please Print)*

Check here if address has changed

Name: _____

Email: _____

Address: _____

Social Security No.: _____

City, State, Zip: _____

Home Phone: _____

ORTHODONTIC EXPENSES

According to regulations outlined in Section 125 of the Internal Revenue Code (IRC) participants cannot be reimbursed in advance of the date of service. Submitting this claim form will allow you to be reimbursed for your banding/initial fee and ongoing monthly fees as services are rendered for the remainder of the treatment period. This form eliminates the need to submit monthly claim forms as treatment services are provided.

Patient Name:

Relationship to Employee:

Treatment Start Date:

Total Treatment Fee:

Banding/Initial Fee:

Estimated Treatment Time in Months:

Expected Insurance Coverage:

Orthodontic Provider:

Orthodontic Contact Information:

I certify that our office will provide Orthodontic care as described above. Our office further certifies that this orthodontic service is for treatment and is NOT strictly for cosmetic purposes.

Orthodontic Provider (Name of Doctor's Office)

Signature of Orthodontic Care Provider

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. The expenses were incurred while I was covered under the Flexible Spending Account(s). I have submitted any health care expenses covered by other health care plan(s) to those plans, but payment has been denied in full or in part, as shown on the attached form(s). Receipts from my service provider(s) for all expenses are attached to this voucher. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax on the amounts paid for any expense improperly claimed under the provisions of the Flexible Spending Account(s).

Signature

Date

Mail To: MyCafeteriaPlan.com 432 East Pearl Street, Miamisburg, OH 45342

Phone: 937-865-6500 Toll-free: 800-865-6543 Fax: 937-865-6502 Email: info@mycafeteriaplan.com

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