

Your Spending Account™ has developed this form to assist you and your orthodontic provider in providing the information necessary to process your reimbursement request. Your provider can also write a letter on his or her letterhead, as long as the letter includes all information included on this form (including the provider's signature, state dental license number, and date).

Reimbursement requests for payment of the entire expense at the beginning of treatment, pay off of existing orthodontic treatment, and lump sum payments (that draw down, but do not pay off the balance) require proof of payment.

Reimbursement requests for regular monthly installments require proof of payment only if the service has not yet been rendered. If the monthly service has been rendered (not for a date of service in the future) then proof of payment is not required.

Proof of payment may be substantiated by:

- Account ledgers (showing the applied payment)
- Banking statements
- Cancelled checks
- Credit card statements
- Invoices (showing the applied payment)

Instructions – Submitting Your Claim & Receipts

To have your claim approved, you must submit 1) this completed form, 2) a claim form, and 3) all supporting documentation to Your Spending Account. Once received, Your Spending Account will typically process your claim within ten days.

Sending Your Claim to Your Spending Account

Fax: 1-888-211-9900

Mail: Your Spending Account™
P.O. Box 78504
Orlando, FL 32878-5040

If faxing, be sure to place the claim form before your itemized receipts and Receipt of Orthodontic Treatment Form. Also, don't include a coversheet.

YOUR spending ACCOUNT™

P.O. Box 785040
Orlando, FL 32878-5040
Fax: 1-888-211-9900

RECEIPT OF ORTHODONTIC TREATMENT FORM

Employee Information

First Name MI Last Name

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Daytime Phone Number Last 4 of SSN (Optional) Employer

Orthodontia Details – To Be Completed by Your Orthodontist

Patient Name

_____/_____/_____
Banding Date (when appliances were applied)

Estimate Length of Treatment
(months)
\$_____
Full Cost of Treatment
(after any discounts)
\$_____
Monthly Installment Amount
(if applicable)

Expense Details – To Be Completed by Your Orthodontist

\$_____
Amount Received

_____/_____/_____
Date

Expense Type (Check One):
☐ Payment of the entire expense at the beginning of the treatment (requires proof of payment)
☐ Payoff of existing orthodontic treatment (requires proof of payment)
☐ Lump sum payment that draws down, but does not pay off, the orthodontic treatment (requires proof of payment)
☐ Regular monthly installment of orthodontic treatment (may require proof of payment)

Orthodontist Certification

By my signature below, I certify that:

- The orthodontic services listed above have begun
- The charges listed above have been paid on the date shown
- The charges listed above are required to receive services

Orthodontist's Signature Date

Provider's State Dental License Number