

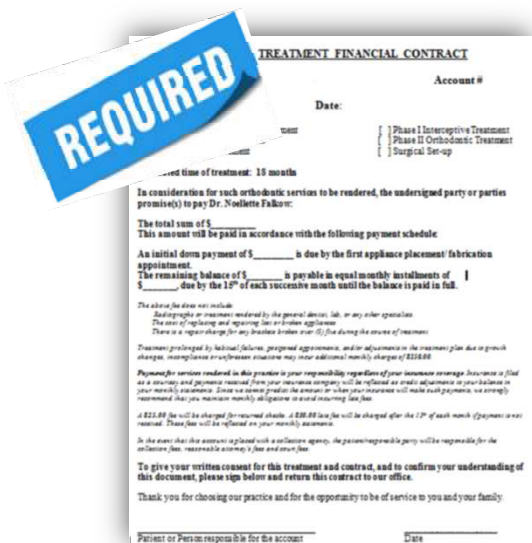
Using your Flexible Spending Account for Orthodontia

With tax advantaged plans such as Flexible Spending Accounts (FSA), the IRS requires itemized receipts for every transaction. This documentation is needed to verify that your expense was eligible under the plan. For Orthodontic treatment that involves a contract or payment plan with your provider, additional information may be requested, such as your Orthodontic Contract and/or Truth in Lending Statement, in order for us to validate that the payment you are claiming falls within eligible FSA Plan Year dates.

All requested information is reviewed to ensure that the expense meets IRS eligibility requirements and keep the plan in compliance.

For **Orthodontic Treatment** expenses, the **Orthodontic Contract** must include six main components:

1. **Total Cost of Treatment**
2. **Any Insurance Payments Applied**
3. **Down Payment (Initial Payment), if any**
4. **Discounts Applied, if any**
5. **Start Date of Treatment**
6. **Length of Treatment**



TREATMENT FINANCIAL CONTRACT

Account # _____ Date: _____

Phase I Interceptive Treatment
Phase II Orthodontic Treatment
Surgical Set-up

Estimated time of treatment: 18 months

In consideration for such orthodontic services to be rendered, the undersigned party or parties promise(s) to pay Dr. Stadelmeier-Palmer:

The total sum of \$ _____

This amount will be paid in accordance with the following payment schedule:

An initial down payment of \$ _____ is due by the first appliance placement/fabrication appointment.

The remaining balance of \$ _____ is payable in equal monthly installments of \$ _____ due by the 15th of each successive month until the balance is paid in full.

The above fees do not include:
Radiographs or treatment rendered by the general dentist, lab, or any other specialist.
The cost of replacing and repairing lost or broken appliances.
There is a separate charge for any broken braces over \$15 for during the course of treatment.

Treatment prolonged by habitual failure, prolonged appointments, and/or adjustments to the treatment plan due to growth changes, incomplete or uneven treatment may incur additional monthly charges of \$250.00.

Payments for services rendered in this practice are your responsibility regardless of your insurance coverage. Insurance is filed as a secondary and payments received from your insurance company will be reflected as credit adjustments to your balance in your monthly statements. Since we cannot predict the amount or when your insurance will make such payments, we strongly recommend that you maintain monthly obligations in order to secure your fee plan.

A \$25.00 fee will be charged for missed visits. A \$50.00 fee will be charged after the 15th of each month (payment is not required). These fees will be reflected on your monthly statements.

In the event that the account is liquidated with a settlement agency, the patient/responsible party will be responsible for the settlement fees, reasonable attorney's fees and court fees.

To give your written consent for this treatment and contract, and to confirm your understanding of this document, please sign below and return this contract to our office.

Thank you for choosing our practice and for the opportunity to be of service to you and your family.

Patient or Person responsible for the account: _____ Date: _____

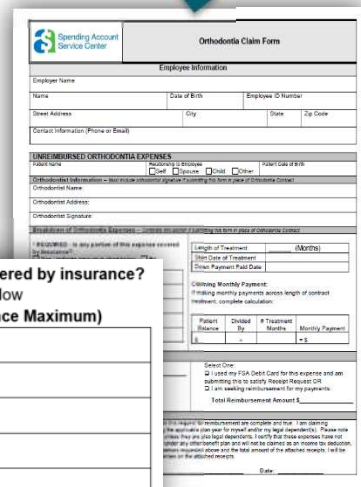
Don't have a contract? Use our **Orthodontia Claim Form**! Have your orthodontic provider complete the claim form in its entirety, sign, and submit for reimbursement. Full instructions are located on Page 2 of the Orthodontia Claim Form.

Payment Options: You can receive your reimbursement for payment in full, lump sum payments, or monthly payments as you receive the service.

- **Payment In Full/Lump Sum Payments** – The patient responsibility due, minus any insurance payments, discounts, etc., may be claimed as long as submitted using service dates within the contracted treatment period. *You cannot claim lump sum payments within a different plan year than when the treatment took place. If submitting for a lump sum payment, any previous payments from your FSA for down payment, initial fee, etc. must be factored in.*
- **Monthly Payments** – In order to receive reimbursement for a monthly payment, the full calculation breakdown must be submitted with your first claim. All six components must be included on your contract in order for us to determine the amount eligible from the corresponding FSA Plan Years. After the contract has been received and noted in your record, you may submit claims for monthly reimbursement over the length of the contract.

Is any portion of this expense covered by insurance?
☐ Yes – Indicate amount in chart below
☐ No (Indicate \$0 in Total Insurance Maximum)

Total Treatment Cost	\$ _____
*Total Insurance Maximum	- \$ _____
Down Payment	- \$ _____
Discounts Applied (if any)	- \$ _____
Patient's Balance	= \$ _____



Orthodontia Claim Form

Employee Information

Employee Name: _____ Date of Birth: _____ Employee ID Number: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Contact Information (Phone or Email): _____

UNREIMBURSED ORTHODONTIA EXPENSES

Phase I: ☐ Interceptive ☐ Phase II: ☐ Orthodontic ☐ Surgical ☐ Other: _____

Orthodontist Name: _____

Orthodontist Address: _____

Orthodontist Signature: _____

Method of Orthodontia Payment – Complete one entry or nothing on form if pay preference listed

☐ Lump Sum: Is any portion of this expense covered by insurance? Yes ☐ No ☐ (Indicate \$0 in Total Insurance Maximum)

☐ Monthly: Length of Treatment: _____ (Months)

Initial Date of Treatment: _____

Down Payment Paid Date: _____

Using Monthly Payment: ☐ Making monthly payments across length of contract (complete calculation)

Patient Balance: _____ Divided By: _____ # Treatment Months: _____ Monthly Payment: _____

Select One:
☐ I certify my FSA Card Limit for this expense and am submitting this to satisfy Required Request OR
☐ I am seeking reimbursement for my payments.

Total Reimbursed Amount: \$ _____

Printed Name: _____ Date: _____

Insurance: If your Orthodontist does not accept insurance and you are being reimbursed directly from your insurance carrier, this amount still must be reported to us to prevent overpayment. You may submit the **Explanation of Benefits (EOB)** issued by your insurance carrier. The full Explanation of Benefits (EOB) will provide the details needed to include with your reimbursement request.

How to Receive Reimbursement:

File Your Claim: For fastest processing, use the online portal to file your Orthodontia Claim! The online portal is fast, convenient and secure! Check your benefit materials for log in instructions and user access credentials. You may also mail, fax, or email your claim to the below address:



Mail: Spending Account Service Center

PO Box 350

Conshohocken, PA 19428

Fax: 800-595-4642

Email: Spending.Accounts@MarshMMA.com

Online: see benefit materials for your employer-specific URL

FSA Debit Card: If your employer offers the FSA Debit Card, skip the claim reimbursement request altogether, and use your MMA Blue Card to pay your orthodontic provider. *Be prepared to submit the full Orthodontic Contract and insurance maximum, as this will still be required to validate your purchase.*

For Claim Forms, eligible expense listings, and additional information, log in to your online consumer portal, WEX Health Cloud and click on Tools & Support. User access credentials vary by employer. Check your benefit materials for log in instructions and user access credentials.

Administrator Notes: As orthodontia treatment typically spans over a period of years, individuals are often charged an initial, up-front payment and then must make periodic payments over the rest of the treatment period. FSA reimbursement is based on service date(s), therefore the expense must be claimed within the active treatment period. The contract Start Date and estimated Length of Treatment are required to determine the amount eligible for reimbursement within the FSA plan year. Per IRS rules, if any portion of the patient treatment is covered by insurance, this must be indicated with your reimbursement request.