Spending Account Service Center

Orthodontia Claim Form

Employee Information

Employer Name			
Name	Date of Birth	Employee ID Number	
Street Address	City	State	Zip Code
Contact Information (Phone or Email)			

UNREIMBURSED ORTHODONTIA EXPENSES

Patient Name	Relationship to Employee	Patient Date of Birth
	☐ Self ☐ Spouse ☐ Child ☐ Other	

Orthodontist Information – *Must include orthodontist signature if submitting this form in place of Orthodontia Contract*

Orthodontist Name:

Orthodontist Address:

Orthodontist Signature:

Breakdown of Orthodontia Expenses – *Complete this section if submitting this form in place of Orthodontia Contract*

*** REQUIRED:**

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	= $

Length of Treatment	_____ (Months)
Start Date of Treatment	
Down Payment Paid Date	

Claiming Monthly Payment:

If making monthly payments across length of contract treatment, complete calculation:

Patient Balance	Divided By	# Treatment Months	Monthly Payment
$	÷		= $

Claim Reimbursement Amount – *A reimbursement check will be sent if you do not select debit card option below*

Select One:

☐ Monthly Payment: Indicate Month(s): _____

☐ Patient's Down Payment

☐ Patient's Total Responsibility

☐ Other:_____

Select One:

☐ I used my **FSA Debit Card** for this expense and am submitting this to satisfy Receipt Request **OR**

☐ I am seeking **reimbursement** for the below amount:

Total Claim Reimbursement Amount: $_____

Authorization

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). Please note that domestic partners and their children are not eligible unless they are also legal dependents. I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested above and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Signature: _____ **Date:** _____

Don't have a contract? Use this form!

Have your orthodontic provider complete the claim form in its entirety, sign, and submit for reimbursement. Once processed Orthodontia treatment costs and treatment months will be on file for future reimbursements.

How to File Orthodontia Claim Form

Step

1. Complete the Employee Information Section of the claim form with participant information.
2. Complete the section titled Unreimbursed Orthodontia Expenses with patient information.
3. Have the Orthodontist complete the Orthodontist Information, as well as, the Breakdown of Expenses section, in place of an Orthodontia Contract. ***This form must be signed by the orthodontic provider if you do not have the actual contract to submit***. You may also attach the Contract and/or Truth in Lending Statement if you have one[and Explanation of Benefits Statement from your Dental Provider].
4. Complete the Claim Reimbursement Amount section, indicating amount and date of expense.
5. Sign the Authorization section. Unsigned claim forms ***cannot be accepted***.
6. Retain copies of the entire claim form and supporting documentation for your records. Documents submitted will not be returned to you.
7. Submit the fully completed claim form and supporting documentation to any one of the following:

! For faster processing, please consider using the online portal to file your Orthodontia Claim! The online portal is fast, convenient and secure!

Online* If you are using this form in place of the contract or receipt, you may file online by selecting the **Reimburse Myself** option, and **upload this form in place of receipt** **Check your benefit materials for log in instructions and user access credentials, or call the Benefit Service Center for assistance logging in.*	**Mail** Spending Account Service Center PO Box 350 Conshohocken PA 19428
Fax 800-595-4642	**Email** claimsubmissions@marshmma.com

Please file your claim promptly, within the plan year in which charges were incurred. It is not necessary to accumulate your claims and submit only at year-end. Promptly submitting claims allows additional information to be requested of you as soon as possible.

For additional information, log in to your online consumer portal, 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 above.