REIMBURSEMENT CLAIM FORM
FOR ORTHODONTIC TREATMENT

PLEASE NOTE: Orthodontic expenses can be reimbursed only after the service has been provided; not when the expense is paid. *The total cost for braces cannot be reimbursed at the time of application, even if it has been paid in full. 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. If payments have been made less frequently than monthly, reimbursements are still made on a monthly basis based on the information below.*

I. EMPLOYEE INFORMATION

Name: _____ Social Security No: _____

Employer: _____

II. ORTHODONTIC EXPENSES

Patient Name: _____

Date of Banding: _____ Fee for Total Treatment: _____

Banding/Initial Fee: _____ Estimated Treatment Time in Months: _____

Monthly Payment: _____

Orthodontic Provider: _____

Address & Telephone Number Of Orthodontic Provider: _____

_____

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.

_____ _____

Signature of Orthodontic Care Provider Date

III. READ CAREFULLY

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Cafeteria Plan or HRA Plan with respect to such expenses. The undersigned fully understand that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense.

_____ _____

Employee Signature Date

Submit by sending to:
July Business Services
Fringe Claims Department
940 Industrial Drive South, Suite 111
Sauk Rapids, MN 56379
Phone 800-682-3826

JULY business services

Documents can be e-mailed to:
cafeteria@julyservices.com
Fax: 1-866-374-7698

INSTRUCTIONS FOR COMPLETING THE ORTHODONTIC REIMBURSEMENT CLAIM FORM

1. Review the note at the top of the claim form to understand the rules regarding reimbursement of orthodontic expenses.

2. Provide your orthodontist with this form, and ask them to complete section II, sign and date the form.

3. After the orthodontist has completed section II (Orthodontic Expenses), the employee should complete the "Employee Information" section.

4. Read the paragraph at the bottom of the form, sign and date the form.

5. Submit the claim form to July Business Services.

6. An automatic claim reimbursement schedule will be setup based on the information provided on the claim form. This form eliminates the need to submit monthly claim forms as treatment services are provided.