ORTHODONTIA INFORMATION FORM

Flexible Benefit Plan

Instructions for Participant: In order to be reimbursed for orthodontic expenses, you must submit a copy of your orthodontia contract. Your contract serves as your "third-party" documentation. If there is any missing information, we will contact your Orthodontist's office directly. In lieu of a contract, the doctor's office can complete this form.

When you submit your initial claim for orthodontic services, request the amount you are required to pay during the entire FSA plan year on your claim form. For example, if your plan year starts January 1 and ends December 31, request the amount you are required to pay during the entire 12-months. If you request your total plan year obligation, we will be able to reimburse you without your having to submit new claims each month. However, while we can reimburse you in accordance with your payment contract, orthodontic services must be rendered (banding completed) before you may be reimbursed. In addition, we will not reimburse more than you have elected for the plan year.

Instructions for Orthodontist's office: This form serves as documentation so the responsible party can be reimbursed for orthodontic expenses through a reimbursement account. Please complete all the information below and return it to the person who asked you to complete this form. DO NOT send this form directly to BASIC pacific. Contact BASIC pacific if you need assistance completing this form.

THIS FORM MUST BE COMPLETED BY ORTHODONTIA OFFICE PERSONNEL TO BE VALID

Contact information *(please type or print clearly)*

NAME OF ORTHODONTIC PRACTICE			**ORTHODONTIST PHONE**
ORTHODONTIST MAILING ADDRESS			
CITY	**STATE**	**ZIPCODE**	
PATIENT FULL NAME *LAST* *FIRST* *MIDDLE INITIAL*			**CURRENT AGE OF PATIENT**
NAME OF FINANCIALLY RESPONSIBLE PARTY (THIS SHOULD BE THE HEALTH FSA PARTICIPANT)			
STATE THE MEDICALLY NECESSARY REASON FOR THIS TREATMENT (expenses for purely cosmetic orthodontia are not eligible for reimbursement)			
DOWN PAYMENT DUE FROM RESPONSIBLE PARTY $	**MONTHLY PAYMENT DUE FROM RESPONSIBLE PARTY** $		**TOTAL NUMBER OF PAYMENTS**
DUE DATE OF FIRST MONTHLY PAYMENT	**DUE DATE OF FINAL MONTHLY PAYMENT**	**ACTUAL BANDING DATE**	

I, the undersigned, certify that the information provided is true and correct. I further certify that services are scheduled to be rendered during the payment period.

PRINT NAME OF PERSON AUTHORIZED TO COMPLETE THIS FORM	**PRINT TITLE OF PERSON AUTHORIZED TO COMPLETE THIS FORM**
SIGNATURE OF PERSON AUTHORIZED TO COMPLETE THIS FORM	**DATE**
BASIC pacific office use only	

BASIC pacific
POST OFFICE BOX 2170 • ROCKLIN, CA 95677 • PHONE: 916.303.7090 • TOLL-FREE: 800.574.5448 • FAX: 916.303.7083
customerservice@basicpacific.com