# Automatic Orthodontia Request Form

46632791 (12/18)

BenefitHelp SOLUTIONS

**PLEASE PRINT CLEARLY**

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

This form is to be completed for any consumer that wants to receive automatic reimbursement for orthodontia expenses. Payments are issued at the beginning of each month for which services are still being provided. If participating in automatic reimbursement for these expenses, the benefits debit card cannot be used to pay the provider.

## Section 1 Account holder information

| * First name | M.I. | * Last name | * Date of birth _____ / _____ / _____ | * Social Security number |
|---|---|---|---|---|

| * Mailing address | * City | * State | * ZIP |
|---|---|---|---|
| * Physical address | * City | * State | * ZIP |

| * Email address | * Contact phone number |
|---|---|

| * Employer |
|---|

## Section 2a Orthodontia information

Please complete this section for the individual receiving orthodontic services/treatment. If you have multiple individuals receiving treatment, please submit each one on a separate form.

| * Start date of treatment (mm/dd/yyyy): **A.** _____ / _____ / _____ | * End date of treatment (mm/dd/yyyy): **B.** _____ / _____ / _____ |
|---|---|
| * Person receiving orthodontic services/treatment | *Monthly cost of treatment $ |

| *Please select only one | |
|---|---|
| ☐ | **Contract attached:** I have attached a copy of the contract or payment plan for each qualifying dependent for which orthodontic services are being provided. **Please skip step 2b.** |
| ☐ | **Orthodontist signature:** My orthodontist has completed and signed **step 2b.** |
| ☐ | **Stop automatic orthodontia:** I have previously enrolled in automatic reimbursement and request that it be stopped, effective (mm/dd/yyyy) _____ / _____ / _____ |

## Section 2b Orthodontist certification

I, _____, certify the information provided on this form is accurate and that services are being provided to the specified individual(s) through the dates indicated in Box A and Box B. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

| * Orthodontist signature | * Date |
|---|---|

## Section 3 Participant certification

To the best of my knowledge, the information provided is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that BenefitHelp Solutions including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit and that, pending approval, reimbursement will begin the first month following the date of my submission.

| * Participant signature | * Date |
|---|---|

**Return the completed form to BenefitHelp Solutions**

**Mail:** BenefitHelp Solutions, P.O. Box 2823, Fargo, ND 58108 **Fax:** 855-778-9837

**Questions?** Contact BenefitHelp Solutions at 855-378-0197, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.