# Orthodontics Reimbursement Support Form

Participant Name: _____SS# _____-____-_____

Participant Company Name: _____

Patient Name: _____

Type of Appliance: ___full banding ___expander ___other

Date Appliances placed: ___/___/___ Expected Months of Treatment:_____

Total Treatment Fee: $_____
Less Estimated Insurance Payment: $_____
Patient Responsibility (after ins): $_____

Provider Name: _____ Phone: (____)_____-_____

Provider signature: X_____

## Reimbursement Options:

☐ Installment Option: Initial/Down Payment: $_____
Monthly Payment: $_____ x _____ Months
Date Monthly Payment begins: ___/____/____

If the treatment is completed before the expected removal date, any unpaid balance can be reimbursed in full with a written statement from the provider showing the appliance removal date and the remaining account balance.

☐ Full Payment Option: $_____

By claiming the entire amount up front, you agree to make no further claims for this service. You will be reimbursed up to your remaining election amount. Proof of payment must be attached to your claim for reimbursement to be approved.