Orthodontic Expense Worksheet/ Continual Reimbursement Form

1 Personal Information

Plan Participant Name (First Name, Last Name)

Name of Person Receiving Service

Participant Employer

Participant Social Security Number (Required)

Instructions

1. Complete the Orthodontic Expense and Service Schedule below
2. If you would like continual reimbursement of your expenses please complete the Continual Reimbursement section
3. Your orthodontic provider's information and signature is required for reimbursement
4. Please attach the Orthodontic Treatment and Financial Agreement. (Required)
5. Send all information to National Benefit Services, LLC

2 Orthodontic Expense and Service Schedule

$ Total Treatment Fee

$ Expected Insurance Coverage

☐ No Coverage If No Insurance Coverage

$ Initial payment (If Any)

Date Paid

$ Ortho Records/Model Fee (If separate from treatment fee)

Date Paid

$ Patients Monthly Payment (after expected insurance)

Beginning Date of Monthly Payments

Expected # of Months in Treatment

	First Year: 20_____	Second Year: 20_____	Third Year: 20_____
January	$	$	$
February	$	$	$
March	$	$	$
April	$	$	$
May	$	$	$
June	$	$	$
July	$	$	$
August	$	$	$
September	$	$	$
October	$	$	$
November	$	$	$
December	$	$	$

3 Continual Reimbursement

Expenses for orthodontia may not be reimbursed under the plan prior to the time the orthodontia care services are rendered. However, you may be reimbursed under the plan after the services are rendered and prior to the time that the payment is due if those expenses are part of a continual reimbursement request. You may use this form to apply for continual reimbursement. No reimbursement may be paid under the continual reimbursement program for any month in which orthodontia services are not rendered. It is your responsibility to advise the plan administrator of the cessation or interruption of such services.

4 Benefit Election

☐ YES! Please sign me up for continual reimbursement of my orthodontia expense.

Your reimbursement will automatically be sent to you each month following NBS receipt of payroll withholdings.

5 Employee Signature

I have reviewed the information on this request form and verify that the information listed above and attached is true and correct. I understand that if any changes regarding the continual payment occur, the company must be notified immediately. Failure to do so could result in additional taxes being applicable for which I would be responsible. I also understand that copies of receipts for payment of these expenses must be forwarded to National Benefit Services, LLC.

Employee Signature

Date

6 Service Provider

Orthodontist Name

Orthodontist Phone Number

I, the undersigned, hereby certify that the above patient will incur/has incurred these expenses.

Orthodontist Signature

Business ID#

P.O. Box 6980 West Jordan, UT 84084 • (855) 399-3035 • Fax (844) 438-1496 • my.nbsbenefits.com