



Orthodontics Reimbursement Support Form

Participant Name: _____ SS# _____ - _____ - _____

Patient Name: _____

Type of Appliance:	_____ full banding	_____ expander	_____ other
Date Appliances placed:	___/___/___	Expected Months of Treatment:	_____
Total Treatment Fee:	\$	_____	
Less Insurance Benefit:	\$	_____	
Patient Responsibility:	\$	_____	
Provider Name:	_____	Phone: (____) _____ - _____	
Provider signature:	X	_____	

Reimbursement Options:

- Monthly Option:** Initial Payment: \$ _____
Monthly Payment: \$ _____ x _____ Months
- Full Amount Option:** \$ _____

If the treatment is completed before the expected removal date, any unpaid balance can be reimbursed in full.

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.