University of Dayton Orthodontic Scheduled Claim Form

myCAFETERIAPLAN.com
FLEXIBLE SPENDING ACCOUNTS

EMPLOYEE INFORMATION *(Please Print)*

☐ Check here if address has changed

Name: _____ SSN: (last four digits) _____

Address: _____ Email : _____

City, State, Zip: _____ Day Phone: _____

ORTHODONTIC EXPENSES

This claim form is for participants who would like to set up an ongoing monthly reimbursement for their orthodontic expenses. This eliminates the need to submit monthly claim forms as services are provided. By having your provider complete this form, a payment schedule can be established to automatically issue a reimbursement directly to you each month.
However, beginning January 1, 2007, the IRS has allowed payment in full for your orthodontic expenses. If this is an option you would like to discuss, please contact our Customer Service Department at 1-800-865-6543.

Patient's Name:		
Treatment Start Date:		
Total Treatment Fee:		**A**
Insurance Payment/Reimbursement:		**B**
Total Out-of-Pocket Expense:		**C =(A minus B)**
Down Payment:		**D**
Remaining Balance:		**E =(C minus D)**
Number of Months of Treatment:		**F**
Monthly Reimbursement Amount Allowed:		**G = (E/F)**
Orthodontic Contact Information:	Name: Address: Phone:	

I certify that our office will provide orthodontic care as described above. Our office further certifies that this orthodontic service is for treatment and is NOT strictly for cosmetic purposes.

_____ _____

Signature of Orthodontic Care Provider Date

READ CAREFULLY

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and were incurred while I was covered under the Flexible Spending Account. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of the Flexible Spending Account.

_____ _____

Participant Signature Date

Mail To: myCafeteriaPlan, 432 East Pearl St., Miamisburg, OH 45342
Fax To: 937.865.6502 Email To: claims@myCafeteriaPlan.com
To contact Customer Service, call 800.865.6543

Access your account information 24 hours a day, seven days a week on our web site: www.myCafeteriaPlan.com

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