ORTHODONTIA REQUEST FORM

This form is to be completed for any participant who wants to receive reimbursement for orthodontia expenses.

1. Complete the information below. Be sure to provide all information requested on this form. If the form is incomplete, your claim will be denied.
2. Forward completed form to Participant Services:
   Email: ParticipantServices@AssociatedBank.com
   Fax: 920-327-6546
   Mail: Participant Services, MS 7004, Associated Bank, PO Box 19097, Green Bay, WI 54307-9097

*Required Fields

Participant Information

*Employer Name (do not abbreviate)

*Participant Name (First, MI, Last)

*Birth Date (MM/DD/YYYY)

*Last 4 Digits of SSN #

*Participant Mailing Address (cannot be a PO Box)

*City

*State

*ZIP Code

*Email Address

*Daytime Phone

Orthodontist 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.

*Orthodontist Name

*Orthodontist Tax ID#

*Person receiving orthodontic services/treatment

Orthodontist Charges

Select method of payment and fill out applicable information. Payments are issued at the beginning of each month for services provided. If participating in automatic reimbursement for these expenses, the benefits debit card cannot be used to pay the provider.

☐ *One-Time Reimbursement ☐ *Automatic Reimbursement

One-Time Reimbursement

☐ *Initial Fee	$		
	*Dollar Amount	*Date of Payment (MM/DD/YYYY)	
☐ *Records Fee	$		
	*Dollar Amount	*Date of Payment (MM/DD/YYYY)	
☐ *Monthly Installment	$		
	*Dollar Amount	*Date of Payment (MM/DD/YYYY)	
☐ *Other	$		

Automatic Reimbursement

For yearly cost of treatment, please divide transaction total by total months of service to determine monthly cost.

*Start Date of Treatment

*End Date of 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.

☐ **Orthodontist signature:** My orthodontist has completed and signed the Orthodontist Certification section.

☐ **Stop Automatic Orthodontia:** I have previously enrolled in automatic reimbursement and request that it be stopped effective:

(MM/DD/YYYY)

Orthodontist Certification

I certify the information provided on this form is accurate and that services are being provided to the specified individual through the dates indicated in Orthodontia Information section. 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

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 by benefit plan documents. I further certify that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Associated Bank, including its affiliates, 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

Frequently Asked Questions

How do I submit my orthodontic expenses for reimbursement?

You have two options for reimbursement of your orthodontic expenses.

A. Fill out the Orthodontic Care Expense Receipt every time you submit for a payment made. Be sure to include all information requested as applicable and have your service provider sign in the Orthodontist Certification section. Submit the Orthodontic Care Expense Receipt with your completed claim form (listed with other claims you are submitting, if any.)
B. Submit a signed copy of your Orthodontic Contract with your first claim for reimbursement. We will then put the contract on file with all relevant information, i.e., total amount of services, initial payment, monthly installments and length of treatment. After this initial submission, you need only submit a claim form for the monthly installments and write “contract on file” on your claim form. We will then be able to process your reimbursement for the dollar amount we have on file per your contract.

What is an Orthodontic Contract?

An Orthodontic Contract (also known as a Service Agreement or Payment Contract) is a document signed by both you and your orthodontic service provider agreeing upon terms of payment for services rendered. This document should contain the following information:

- Name of service provider
- Total cost of services less insurance payment or provider discounts
- Initial payment made (if any)
- Monthly payment amount agreed upon
- Number of months treatment and payments are expected to last
- Date treatment began
- Name of person receiving treatment
- Signatures of service provider and responsible party