

Under the IRS regulations, no expense can be reimbursed through an FSA until the service has been incurred. Orthodontic treatment covers many months and there is usually a service contract between the provider and patient. This worksheet is for FSA participants who would like ongoing monthly reimbursements for their orthodontia expenses. By having your provider sign off on this payment schedule, MBA Administrators will begin issuing reimbursements directly to you each month.

Simply submit this worksheet with the Flex Reimbursement Request Form to MBA Administrators along with proof of payment for each monthly payment if applicable. Questions please call (208) 888-2626 or email INFO@mba-admin.com

EMPLOYEE INFORMATION

Employee Last Name	First Name	SSN
Mailing Address	City, State and Zip	Day Phone
Email	Employer	

PATIENT INFORMATION

Patient's Name	Patient Date of Birth	
Date First Payment Due	Date Last Payment Due	Treatment Start Date & End Date

ORTHODONTIC EXPENSES

Total Amount for Orthodontic Services		\$	
Provider Discounts	<minus>	\$	
Insurance Payments/Reimbursements (if applicable)	<minus>	\$	
Total Out of Pocket Expense	< = >	\$	
Down Payment	<minus>	\$	
Remaining Balance	< = >	\$	
Number of Months of Treatment	<divide>		
Monthly Reimbursement Amount Allowed <i>(within current FSA plan year)</i>		\$	

PROVIDER INFORMATION

Orthodontic Service Provider Name	Orthodontic Service Provider Phone Number
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I certify that our office will provide the orthodontic care as described above. Our office further certifies that this orthodontic service is for medically necessary treatment and is NOT for strictly cosmetic purposes.

Orthodontic Service Provider Signature

Date

Please submit this worksheet and a completed claim form to:

Fax: (208) 887-1313
 Mail: MBA Administrators
 Attn: FSA Plan
 PO Box 370 | Meridian, ID 83680
 Email: CLAIMS@mba-admin.com