

SECTION 125 Health Care Reimbursement Account Orthodontia Services Worksheet

Please have your provider of service complete this form for you to use when estimating your necessary plan contributions. Submit this form with your first claim for reimbursement, along with a copy of your treatment contract and Explanation of Benefits (EOB) paid by your insurance.

Employee Name _____ Soc. Sec. # _____ - _____ - _____
(Please Print)
 Address _____

Patient's Name _____

Date Services Began: _____ Total Charges: \$ _____
(Include copy of signed payment contract)

Provider of Service: _____ Tax ID #: _____

Address _____ () _____

Estimated Length of Treatment _____ Anticipated Insurance Payment: _____

Treatment Plan And Services To Be Provided

1ST Year Charges Incurred: \$	Services To Be Provided (Use back of sheet if necessary)
2nd Year Charges Incurred: \$	Services To Be Provided (Use back of sheet if necessary)
3rd Year Charges Incurred: \$	Services To Be Provided (Use back of sheet if necessary)
4th Year Charges Incurred: \$	Services To Be Provided (Use back of sheet if necessary)



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