Orthodontic Reimbursement Procedures & Claim Form

Orthodontia treatment is scheduled over a predetermined period of time and expenses are "incurred" throughout treatment. Orthodontia services are considered long-term treatment plans because of this distinction. The IRS requires that services be "incurred" during the Plan Year to be eligible for reimbursement regardless of how payment is made. The number of months of orthodontia treatment may exceed the number of months in your Plan Year. The expenses may span over more than one Plan Year. Expense is considered "incurred" over the period of time that the braces and services are provided.

Member Information

First Name | MI | Last Name | Social Security Number *(required)* | Employer Name

Filing Instructions

Third-party documentation of this expense is required. You have two options for providing this information to Flyte HCM.

1. If your orthodontist has given you a treatment plan that matches what you have written in the *Treatment Plan Specifics* section, this should be included when you forward this form to Flyte HCM.
2. If your treatment plan does not include all of the information needed to verify the Treatment Plan Specifics, your orthodontist may complete the *Orthodontia Provider Certification* section. Please include a copy of your treatment plan when you forward this form to Flyte HCM also.

Please forward the completed form to Flyte HCM by fax to 952.666.7454 or by email to **claims@flytehcm.com**. After Flyte HCM has received and processed this form, you will receive an ***Orthodontia Reimbursement Confirmation*** letter from Flyte HCM confirming reimbursement amounts and schedule. Please keep a copy of all documentation available, such as this form and the confirmation letter. If you choose not to automatically carry over your reimbursement across Plan Years, you will need to resubmit this information to Flyte HCM.

Treatment Plan Specifics

Patient Name _____ Orthondontia Provider/Clinic _____

Actual Treatment Start Date _____

Expected Duration of Treatment _____
(Number of Months)

Total Cost of Treatment $ _____

Less Amount Covered by Insurance - _____

Total Patient Responsibility $ _____

Down Payment Requested $ _____
(maximum allowed is 25% of patient cost)

Orthodontia Provider Certification
(required if treatment plan documentation is incomplete)

Orthodontist _____

Date Signed/Completed _____

Signature of Provider *Signature certifies that the treatment plan information provided is accurate and correct.*

Reimbursement Request

Select one of the following options for your reimbursement.

☐ Please submit my orthodontia expenses as an automatic recurring monthly claim that will continue through the entire treatment period. I authorize Flyte HCM to continue this reimbursement across multiple Plan Years, if required. I understand that if I wish to end the reimbursement early, I need to request this in writing. If I want to restart my monthly reimbursements later, I understand that I will need to submit my ***Orthodontia Reimbursement Confirmation*** letter to begin automatic recurring monthly claims next year.

☐ Please submit my orthodontia expenses as an automatic recurring monthly claim for this current Plan Year only. I understand that I will need to submit my ***Orthodontia Reimbursement Confirmation*** letter to begin recurring monthly claims next year.

☐ My employer offers the Flyte benefit debit card and I wish to pay my orthodontia provider directly. I do not wish to receive automatic monthly reimbursements. The ***Orthodontia Reimbursement Confirmation*** will be used to validate the monthly payments I will make to my provider. I understand that I will need to provide additional documentation for any payments made to my orthodontist that do not match the information provided.

Certification & Acknowledgement

Reimbursement will be made in accordance with all Plan guidelines. The expenses were incurred by my eligible dependents and/or myself. I have not and do not expect to be reimbursed for these expenses by any other source. Reimbursement is being requested after all other benefit payments from all other available plans have been completed. These expenses will not be deducted on my individual income tax return. I accept responsibility for the proper treatment of benefits paid under the Plan with respect to eligibility, income tax reporting and liability.

Signature of Member *Please be advised - unsigned forms cannot be processed.* Date

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Example of Orthodontic Treatment Reimbursement

To determine eligibility of expenses for orthodontia, please use the following guideline:

Scenario: Billy gets braces in January 2020 and is scheduled to be in braces until December 2021. The treatment period is 24 months. The total cost of the treatment is $4,000. Dental insurance coverage has a $1,000 lifetime maximum benefit for orthodontia.

• Total Cost of Treatment	$4,000.00	
• Less Insurance Payment	-$1,000.00	
• Patient Responsibility	**$3,000.00**	
• Down Payment *(as requested by your orthodontist; not to exceed 25% of total patient cost)*	-$750.00	First month (January 2018) reimbursement *bands/braces must be placed prior to receiving reimbursement*
• Balance Remaining	**$2,250.00** *divided by 23 months*	

01/2020	$750	1st Month	01/2021	$97.83	13th Month
02/2020	$97.74	2nd Month	02/2021	$97.83	14th Month
03/2020	$97.83	3rd Month	03/2021	$97.83	15th Month
04/2020	$97.83	4th Month	04/2021	$97.83	16th Month
05/2020	$97.83	5th Month	05/2021	$97.83	17th Month
06/2020	$97.83	6th Month	06/2021	$97.83	18th Month
07/2020	$97.83	7th Month	07/2021	$97.83	19th Month
08/2020	$97.83	8th Month	08/2021	$97.83	20th Month
09/2020	$97.83	9th Month	09/2021	$97.83	21st Month
10/2020	$97.83	10th Month	10/2021	$97.83	22nd Month
11/2020	$97.83	11th Month	11/2021	$97.83	23rd Month
12/2020	$97.83	12th Month	12/2021	$97.83	24th Month

Reimbursement Schedule

If the Flexible Benefits Plan Year begins January 2020:

01/01/2020 - 12/31/2020 Plan Year - You are eligible for the $750.00 down payment (Jan 2020) and 11 monthly payments (Feb 2020 - Dec 2020) for a total annual of $1,826.13.

01/01/2021 - 12/31/2021 Plan Year - You are eligible for 12 monthly payments (Jan 2021 - Dec 2021) for a total annual of $1,173.96. If you have chosen to automatically carry over your reimbursement in to the following Plan Year, you will not have to submit any additional information. Otherwise, you will need to submit your ***Orthodontia Reimbursement Confirmation*** letter to begin recurring monthly claims for this Plan Year.

If the Flexible Benefits Plan Year Begins July 2020:

07/01/2020 - 06/30/2021 Plan Year - You are eligible for 12 monthly payments (Jul 2020 - Jun 2021) for a total annual of $1,173.96. The down payment was incurred prior to the start of the Plan Year.

07/01/2021 - 12/31/2021 Plan Year - You are eligible for 6 monthly payments (Jul 2021 - Dec 2021) for a total annual of $586.98. If you have chosen to automatically carry over your reimbursement in to the following Plan Year, you will not have to submit any additional information. Otherwise, you will need to submit your ***Orthodontia Reimbursement Confirmation*** letter to begin recurring monthly claims for this Plan Year.

The above scenario is established for purposes of illustration only. Costs and lengths of treatment will vary.