NATIONAL BENEFIT SERVICES, LLC
Customer Care • Knowledge and Expertise • Organizational Excellence

Orthodontic Expense Worksheet/Continual Reimbursement Form

Personal Information

Plan Participant Name	Name of Person Receiving Services
Plan Participant Social Security Number	Participant Employer

Instructions

1. Complete the Orthodontic Expense and Service Schedule below
2. If you would like continual reimbursement of your expenses please complete the Continual Reimbursement section
3. Your orthodontic provider's information and signature is required for reimbursement
4. Please attach the Orthodontic Treatment and Financial Agreement. (Required)
5. Send all information to National Benefit Service, LLC

Orthodontic Expense and Service Schedule

Total Treatment Fee	Expected Insurance Coverage	If No Insurance Coverage
$	$	☐ No Coverage
Initial payment (If Any) Date Paid	Ortho Records/Model Fee (If separate from treatment fee)	Date Paid
$	$	
Patients Monthly Payment (Amount after expected insurance)	Beginning Date of Monthly Payments	Expected # of Months in Treatment
$		

	First Year: 20__	Second Year : 20__	Third Year: 20__
January	$	$	$
February	$	$	$
March	$	$	$
April	$	$	$
May	$	$	$
June	$	$	$
July	$	$	$
August	$	$	$
September	$	$	$
October	$	$	$
November	$	$	$
December	$	$	$

Continual Reimbursement

Expenses for orthodontia may not be reimbursed under the plan prior to the time that the orthodontia care services are rendered. However, you may be reimbursed under the plan after the services are rendered and prior to the time that the payment is due if those expenses are part of a continual reimbursement request.

You may use this form to apply for continual reimbursement. No reimbursement may be paid under the continual reimbursement program for any month in which orthodontia services are not rendered. It is your responsibility to advise the plan administrator of the cessation or interruption of such services.

☐ **YES! Please sign me up for continual reimbursement of my orthodontia expense.**

Your reimbursement will automatically be sent to you each month following NBS receipt of payroll withholdings.

I have reviewed the information on this request form and verify that the information listed above and attached is true and correct. I understand that if any changes regarding the continual payment occur, the company must be notified immediately. Failure to do so could result in additional taxes being applicable for which I would be responsible. I also understand that copies of receipts for payment of these expenses must be forwarded to National Benefit Services, LLC.

Employee Signature	Date
X	

Service Provider

Orthodontist Name	Orthodontist Phone Number

I, the undersigned, hereby certify that the above patient will/has incurred these expenses.

Business ID#	Orthodontist Signature
	X

National Benefit Services, LLC

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Email: claims@nbs-i.com (PDF, TIFF or JPEG files only)