Continual Reimbursement Request

Orthodontia Care Expenses

Please send completed form and required documentation to National Benefit Services.

1 Personal Information

Employee Name (First Name, Last Name)

Employee Social Security Number (Required)

Employee Street Address, City, State, Zip Code

Name of Person Receiving Service

Employer Name

Employee Email Address

2 Important Information

Completing this form will allow you to set up automatic reimbursements each month during the current plan year for your orthodontia expenses.

- Expenses for orthodontia may not be reimbursed under the plan prior to the time the services are rendered.
- No reimbursement may be paid for any month in which services are not rendered. It is your responsibility to notify NBS of the cessation or interruption of such services.
- **Annual expenses may not exceed $2,750 per employee filing individual tax returns.**

3 Continual Reimbursement Request Instructions

1. Completely fill out each section of the first page of this form.
2. Sign and date the bottom of this form. We are unable to complete your request if the form is not signed.
3. Submit the completed first page of this form to NBS at the beginning of your plan year.

- You will need to submit a new continual reimbursement form at the beginning of each plan year if you wish to participate in the continual reimbursement program.

3a Orthodontia Expense Worksheet

1. Complete the Orthodontic Expense Worksheet below to determine monthly reimbursements.
2. **Please attach the Orthodontic Treatment and Financial Agreement (Required).** Your orthodontic provider's information and signature is required for reimbursement. Page 3 is a copy of NBS' Orthodontic contract you may ask your provider to fill out.

$ Total treatment fee

$ Expected insurance coverage

☐ No Insurance Coverage

$ Initial payment *(if any)*

Date paid

$ Ortho records/model fee *(If separate from treatment fee)*

Date paid

$ Patients monthly payment (after expected insurance)

Date of First Payment

Expected # of months in treatment

$ Amount of last payment

☐ Orthodontic Treatment and Financial Agreement attached?

4 Employee Signature

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, National Benefit Services 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 I am responsible for retaining copies of receipts for payment of these expenses per IRS regulations, and they must be forwarded to National Benefit Services at the end of each plan year along with the second page of this form to be able to sign up for the continual reimbursement program the following year.

Employee Signature

Date

Please fax, mail, or email your continual reimbursement form and/or receipts to the following:

Mail: National Benefit Services, LLC, 430 W 7th Street, Suite 219393, Kansas City, MO 64105-1407

Email: service@nbsbenefits.com (PDF, TIFF, or JPG files only)

NBS Orthodontic Contract

1 Personal Information

Plan Participant Name (First Name, Last Name)

Name of Person Receiving Service

Participant Employer

Participant Social Security Number (Required)

Instructions

1. Complete the Orthodontic Expense and Service Schedule below
2. Your orthodontic provider's information and signature is required for reimbursement
3. This form must be submitted along with a Claim Form or Continual Reimbursement Form unless you are using your NBS Card for payment on services
4. Send all information to National Benefit Services, LLC

2 Orthodontic Expense and Service Schedule

$ Total Treatment Fee

$ Expected Insurance Coverage

☐ No Coverage If No Insurance Coverage

$ Initial payment (If Any)

Date Paid

$ Ortho Records/Model Fee (If separate from treatment fee)

Date Paid

$ Patients Monthly Payment (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	$	$	$

3 Employee Signature

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 Orthodontic Contract occur, NBS must be notified immediately. Failure to do so could result in additional taxes being applicable for which I would be responsible.

Expenses for orthodontia may not be reimbursed under the plan prior to the time 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. It is your responsibility to advise the plan administrator of the cessation or interruption of such services.

Employee Signature

Date

4 Service Provider

Orthodontist Name

Orthodontist Phone Number

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

Orthodontist Signature

Business ID#

Please fax, mail, or email your claim form and receipts to the following:

Mail: National Benefit Services, LLC, P.O. Box 6980, West Jordan, UT 84084

Fax: (844) 438-1496

Email: service@nbsbenefits.com (PDF, TIFF, or JPG files only)