State of Hawaii Island Flex
Flexible Spending Accounts (FSA)
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, the company 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 219393, Kansas City, MO 64121-9393

Fax: (844) 438-1496

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