

# 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 6980, West Jordan, UT 84084

**Fax:** (844) 438-1496

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