

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)

State of Hawaii Island Flex Flexible Spending Accounts (FSA) 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

State of Hawaii

Employer Name

Employee Email Address

2 Orthodontia Instructions

1. Complete the Orthodontic Expense Worksheet (Section 2a) below and sign Section 5.
2. **Please attach the Orthodontic Treatment and Financial Agreement (Required).** Your orthodontic provider's information and signature is required for reimbursement.
3. You are responsible for retaining your previous year receipts for reimbursement. Please submit your receipts yearly in order to continue participating in the continual reimbursement program.

2a Orthodontic Expense Worksheet

\$ _____ Total treatment fee	\$ _____ Expected insurance coverage	<input type="checkbox"/> 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	<input type="checkbox"/> Orthodontic Treatment and Financial Agreement attached?		

3 Continual Reimbursement

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

4 Benefit Election

Yes! Please sign me up for continual reimbursement of my orthodontia expense.

5 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, NBS 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, and they must be forwarded to National Benefit Services, LLC each year along with this form to continue participating in the continual reimbursement program.

Employee Signature

Date