Benefit Advantage
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RECURRING ORTHO CARE
REIMBURSEMENT REQUEST FORM

Please Print:

EMPLOYER NAME:	
EMPLOYEE NAME:	
ADDRESS:	
SOCIAL SECURITY #:	
DAYTIME PHONE #:	

I verify that I make regular ongoing payments to:	
Name of Provider:	
For (Name of Patient)	

ORTHO CONTRACT MUST BE ATTACHED

The charge for the care is $_____ per month, beginning on _____ & ending on _____.

Start Date of treatment _____ Term of Treatment_____

I understand that reimbursements will be made only to the extent that my Flexible Spending Account annual election allows. Any unused funds remaining in the account at the end of the plan year will be forfeited.

I have attached a signed statement from the above stated Provider verifying the amount and frequency of charges. I agree that if the amount changes or if for any reason the expenses are not incurred as scheduled, I will notify Benefit Advantage immediately in writing.

This form is only valid for the current plan year.

Signature_____ Date _____
Plan Participant