RECURRING ORTHODONTIA REIMBURSEMENT REQUEST FORM FAX: 1-888-207-2310

If you pay your Orthodontic provider fixed, regular payments over the course of multiple months, you can use this claim once a year, rather than with each payment you make.

Employee Info:			
	Your Name	Your Employer	
	Street Address	Last 4 # of your SSN	Birth Date
	City State & Zip Code	Your Email Address	

Service & Provider Info:			
	Provider Name	Patient Name	
	Provider Address	Date the Orthodontic appliances were first applied/installed	
	City, State & Zip Code	The monthly orthodontia installment payment	$
	Provider Phone Number	Payment Beginning Date	Payment Ending Date

☐ **CHECK HERE FOR PAY MY PROVIDER** **Pay My Provider** option may not be available and, if not, the reimbursement will be sent to you directly. Pay My Provider payments are sent to the provider monthly subject to a minimum check amount of $25 and limited by the benefits available at the time of the scheduled payment.

To support your claim, please submit this completed form along with a copy of your Orthodontia Contract/Financial Agreement as well as a bill or statement to document the date the Orthodontic appliances were first installed.

I hereby certify, understand and agree that: I make regular payments to the Orthodontist for services as detailed in this form and I request recurring reimbursement for those expenses; **I will immediately notify FlexToday if this arrangement changes;** The expenses submitted for reimbursement have not been reimbursed or paid previously and I will not seek payment or reimbursement under any other benefit plan for these expenses; These expenses were or will be incurred during the coverage period by either me or my eligible dependents; I assume the responsibility to maintain substantiating documents for all claims; I understand that this claim form will not be returned to me and I am responsible for retaining my own copy; I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim; I am liable for payment of any taxes and penalties, federal, state or local, related to expenses claimed or paid that are not eligible expenses under the Plan(s); These expenses cannot be claimed as credits or deductions on my personal tax return if reimbursed or paid from the Plan(s); I have received a copy of the Summary Plan Description(s) and understand that this claim is subject to the terms and requirements of the Plan(s), including but not limited to eligibility, coverage period and claims filing deadlines, and; I may receive notifications by email instead of mail and I understand that I must notify FlexToday in writing to rescind this authorization to send notifications by email. Finally, I understand and agree that FlexToday, Inc. will not be responsible for any late charges or overdraft fees related to this claim.

Employee Sign Here	Date Signed

FlexToday, Inc. • PO Box 16099 • Fresno, CA 93755-6099 • Ph: 559-432-6800 or 800-995-5373
Claims Fax 1-888-207-2310 • **Secure Claims Portal Link**

This "recurring claim" will expire on the "Payment Ending Date" above or the **last day of the current calendar year** in which the claim form is received, **whichever is earlier**. You can send claims by fax, mail or electronically (scanned) at the Secure Claims Portal. **We do not accept claims by email**. Unidentified files and files executable formats (.exe, .zip, .eml, .com, .net, .html, vbs, etc.) will be deleted without opening or notice and will not be considered a claim submission. **FlexToday, Inc. 03-2017 ORTHORECURRING.pdf**