usbank
Healthcare Payment Solutions

Automatic Orthodontia Request Form

This form is to be completed for any participant that wants to receive automatic reimbursement for orthodontia expenses. Payments are issued at the beginning of each month for which services are still being provided. If participating in automatic reimbursement for these expenses, the benefits debit card cannot be used to pay the provider.

Step 1: Participant Information

*=Required Fields

*Employer Name (Do not abbreviate)

*Employee ID

*Participant Name (First, MI, Last)

*Social Security Number

Changes Only

Participant Mailing Address (For changes/updates only)

Changes Only

City

State

Zip

*Day Telephone

Changes Only

Email Address (if provided, all account notifications will be sent via email)

Step 2: Orthodontia Information

A.

*Start date of treatment (mm/dd/yyyy)

B.

*End date of treatment (mm/dd/yyyy)

*Person receiving orthodontic services/treatment	*Monthly Cost of Treatment
	$
	$
	$

$

*Total Monthly Reimbursement Request

*Please select only one

- ☐ **Contract Attached:** I have attached a copy of the contract or payment plan for each qualifying dependent for which orthodontic services are being provided. **Please skip Step 2a.**
- ☐ **Orthodontist Signature:** My orthodontist has completed and signed **Step 2a**.
- ☐ **Stop Automatic Orthodontia:** I have previously enrolled in automatic reimbursement and request that it be stopped, effective _____ *(mm/dd/yyyy)*.

Step 2a: Orthodontist Certification

I, _____, certify the information provided on this form is accurate and that services are being provided to the specified individual(s) through the dates indicated in Box A and Box B. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

*Orthodontist Signature

*Date

Step 3: Participant Certification

To the best of my knowledge, the information provided is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that U.S. Bank, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit and that, pending approval, reimbursement will begin the first month following the date of my submission.

*Participant Signature

*Date

Mail signed form and any documentation to:

U.S. Bank Healthcare Payment Solutions, c/o HCB CS, P.O. Box 6122, Fargo, ND 58108-6122

Fax: (888) 403-5029. Questions? Please call U.S. Bank Consumer Services at **(877) 470-1771** (M-F, 7 a.m-7 p.m. CT).

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