



VitaFlex Orthodontia Expense Claim Form

Employee Data

Company Name:	
Employee Name:	
Employee Social Security or ID Number:	

Treatment Plan

Provider Name:		
Patient Name/Relationship:		
Estimated Months of Treatment:		
Banding Date:		
Total Amount Charged:		
Up Front Fee:		
Insurance Information:	Insurance Provider:	Benefit Amount:

I certify that the above referenced patient is under my care for orthodontia and that the dates, charges, and treatment information are accurate and correct.

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Date

Provider Signature

Reimbursement Request

Date of Payment	Amount Paid for Ortho Treatment
	\$

Verification

To the best of my knowledge and belief, the statements in this medical expense claim form are complete and true. I certify these claims are for valid medical expenses provided on the dates indicated and that these expenses were incurred while I was actively participating in the VitaFlex Medical Reimbursement Plan. *These expenses have not been reimbursed under the VitaFlex plan previously nor have they been reimbursed under any other health plan. Additionally, I will not submit these expenses for reimbursement under any insurance plan or from any other source.* I understand that these expenses may not be used to claim any federal income tax deduction or credit. I understand that I alone am responsible for the sufficiency, accuracy and validity of all information relating to this claim. If any claim for reimbursement is not an eligible expense under the plan, I will be responsible for payment of all related liabilities, including federal and state income taxes and any applicable penalties resulting from improper reimbursement from the plan.

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Date

Employee Signature

New Phone/Address (Complete Only if Needed)

New Preferred Phone Number:	()
New Email Address:	
New Home Address:	

A photocopy of this form may be used if additional copies are needed.
For fastest service, fax claims to 650-964-FLEX (3539) or email claims to claims@vitamail.com.