



**VitaFlex  
Orthodontia Expense  
Consolidated Claim Form and Treatment Plan**

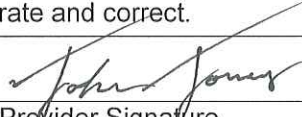
**Employee Data**

Company Name:	<b>Vita</b>
Employee Name:	<b>Jane Smith</b>
Employee Social Security:	<b>123-45-6789</b>
Personal Information Confirmation:	<input checked="" type="checkbox"/> No Changes <input type="checkbox"/> Phone/Address Change <i>(Complete at Bottom of Page)</i>

**Treatment Plan**

Provider Name:	<b>Dr. Jones</b>	
Patient Name/Relationship:	<b>John Smith</b>	
Estimated Months of Treatment:	<b>24 Months</b>	
Banding Date:	<b>01/15/07</b>	
Total Amount Charged:	<b>\$5500</b>	
Up Front Fee:	<b>\$1200</b>	
Insurance Information:	Insurance Provider: <b>Guardian</b>	Benefit Amount: <b>\$500</b>

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.

<b>01/15/07</b>	
Date	Provider Signature

**Reimbursement Request- (Proof of payment is required)**

Date of Payment	Amount paid for Ortho treatment
<b>01/15/07</b>	<b>\$ 1200</b>

**Verification**

To the best of my knowledge and belief, the statements in this medical expense claim form are complete and true. I certify these expenses 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 do not expect any of these expenses to be reimbursable elsewhere (except as noted under Insurance Information) in the future.* 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.

<b>01/15/07</b>	<b>Jane Smith</b>
Date	Employee Signature

**Phone/Address Change (if applicable)**

Daytime Phone Number:	(      )
Evening Phone Number:	(      )
Email Address:	
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)**

**STATEMENT OF SERVICES RENDERED**

**Dr. Joseph M. Jones, DDS**

516 Altos Oaks Drive  
Suite # 4  
Los Altos, CA 94024  
(650) 948-3845

**Chart No**  
B057

**Page No**  
1

**BILLING DATE**  
01/15/07

**GUARANTOR NAME AND MAILING ADDRESS**

Jane Smith  
567 Palm Street  
Mountain View, CA 94040

PATIENT	DATE	TOOTH	DESCRIPTION	CHARGE	CREDIT
<b>John Smith</b>	01/15/07		<b>Ortho Banding</b>	\$1200	
John Smith	<b>01/15/07</b>		<b>Up Front Fee</b> <b>Visa/MC Payment</b> Thank You		<b>\$1200</b>

This provider receipt is sufficient for an orthodontia reimbursement because it contains all the necessary information:

- 1) Provider's name
- 2) Patient's name
- 3) Type of service
- 4) Total cost of service
- 5) Date of payment

Please note that documentation for orthodontia expenses is different than for other medical expenses. For an example of sufficient documentation for a medical expense, please see the Medical Example.

PRIOR BALANCE	CURRENT CREDITS	CURRENT CHARGES	NEW BALANCE
0.00	1200.00	1200.00	0.00

PATIENT	DATE	TIME	REASON
John Smith	02/15/07	10:15AM	Ortho Adjust