Benefit Advantage
PO Box 5546 De Pere, WI 54115-5546
Phone (800) 686-6829
Fax (920) 339-0038
E-mail: claims@benadvan.com

RECURRING ORTHO CARE REIMBURSEMENT REQUEST FORM

Employer Name:

Employee Name:

Address:

Social Security #:

Daytime Phone #:

ORTHO CONTRACT MUST BE ATTACHED

☐ 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.

Name of Provider:

Name of Patient:

Ortho charge:$_____ per month, beginning on:_____/_____/_____ & ends on :_____/_____/_____

Start Date of Treatment: _____/_____/_____ Term of Treatment: _____/_____/_____

This claim form is only valid for the current plan year and will be posted to your Flexible Spending Account at the end of the first full week of every month.

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of $10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the $10.00 fee.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

The Internal Revenue Service regulates this FSA Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses quality for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Signature:_____ **Date:**_____/_____/_____
Plan Participant Name

You may review your account at www.benefitadvantage.com for balance details.