

Form Completion Guide

STEP 1: Participant Information

- Please write legibly. Missing information may delay the processing of your claim.
- Date(s) Expense Incurred: Provide a date the service incurred.
- Person Receiving Product/Service: Indicate what family member is receiving the service.
- Amount Requested per Month: Provide amount to be reimbursed monthly.
- **If there are any changes in the information provided, it is the participants' responsibility to notify Discovery Benefits in a timely manner.**

STEP 1A: Changes Only

- Checking this box will stop your auto orthodontia. Indicate the first month affected by this change.

STEP 2: Payment Schedule Date

- Start Date of Monthly Installments with Discovery Benefits Inc: Provide a date to start monthly installments.
- End Date of Monthly Installments with Discovery Benefits Inc: Provide a date to end monthly installments.

STEP 3: Reimbursement Information

- Please have your orthodontist fill out and sign step 3.

STEP 4: Participant Certification

- Sign and date the form after reading the Participant Certification. Your signature is required for reimbursement.

Form Submission Guide

Determine the method that you prefer to submit your auto request

1. Fax toll free to 1-866-451-3245
2. Mail to PO Box 2926, Fargo, ND 58108-2926

Discovery Benefits will process your claim promptly (two business days from receipt). If there are any concerns about your claim, you will be notified in writing.

Would you like to receive your refund via free direct deposit?

Direct deposit enrollment forms can be found online at discoverybenefits.com

Automatic Orthodontia Request Form



If you would like to receive automatic orthodontia reimbursement, please complete one of the two options below:
1. Complete Steps 1, 2 and 4. Attach a contract or letter from your orthodontist outlining your payment plan; or
2. Complete Steps 1, 2 and 4. Submit this form to your orthodontist to complete and sign in Step 3.

STEP 1 - Participant Information -- Missing information may delay the processing of your reimbursement.

Name Employer

Social Security Number Employee ID #

Date(s) Expense Incurred	Person Receiving Product/Service	Amount Requested per Month

STEP 1A - For Changes ONLY, please fill out 1A.

Please Stop Auto Ortho

First month affected by change _____

STEP 2 – Payment Schedule Date.

Start Date of Monthly Installments with Discovery Benefits _____ (mm/dd/yyyy)

End Date of Monthly Installments with Discovery Benefits _____ (mm/dd/yyyy)

STEP 3 – Orthodontist Information (to be completed by Orthodontist).

Please complete the orthodontist provider information and sign below to allow automatic reimbursement for this participant.

The participant named above is enrolled in an employer sponsored health care reimbursement account. Through this pre-tax account, medical care expenses are deducted from his/her paycheck on a pre-tax basis and may be requested to reimburse eligible medical care expenses that are incurred. This participant has requested regularly scheduled payments each month for reimbursement of orthodontia care services based on the orthodontist payment plan. The IRS requires that proof of services (a statement or receipt) be provided by you, the service provider. Instead of submitting a receipt each month for reimbursement, this form will allow reimbursements to be sent to the participant automatically each month.

I, the orthodontist named below, have read the above and understand and verify that the participant listed above receives orthodontist care services from me for which he/she regularly pays \$_____ per month through _____(mm/dd/yyyy).

Orthodontist Name	Orthodontist Address

Orthodontist Signature _____ Date _____

STEP 4 - Participant Certification: To the best of my knowledge and belief, my statements on this form are complete and true. I certify that the reimbursement requests I'm submitting are IRS eligible expenses and that I have not been previously reimbursed for these expenses, nor am I seeking reimbursement for these expenses from insurance or any other source. I also understand that Discovery Benefits Inc, its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I certify that the expense listed above qualify for reimbursement under the IRS guidelines and have been incurred by me or eligible members of my family. I authorize a deduction in my account in the amount of the reimbursement. I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid expenses under the Plan. If orthodontic care services cease or decrease from the amount that is stated above, I understand that it is my sole responsibly to inform Discovery Benefits Inc in a timely manner of the change I understand that I am responsible for the validity of claims submitted to my Medical Spending Account, and that these expenses occurred during my coverage period, within the plan year. I certify that this expense was for medical care, not cosmetic or general health purposes. I certify that these expenses have not been reimbursed under the above mentioned accounts or by other source, and will not be claimed as deductible expenses when I file my personal tax returns. . . Please retain a copy of all documentation for your records in the event of an IRS audit.

Participant Signature _____ Date _____

This form cannot be accepted without the participant's signature.