FLEXIBLE SPENDING ACCOUNT

ORTHODONTIC SERVICES RECEIPT

Attach to the Payment Request form

Employee Information

Employer: ______________________________

Employee Name: ______________________________ Date ______________

Patient Name: ______________________________ Phone: ______________

Service Provider Information

Dentist Name: ______________________________ Phone: ______________

Address: ______________________________

____

____

____

Treatment Information

Start Date: _______/_______/_______ Total Fee: $ ____________________

Initial Fee: $ ______________________ for ______________________ Months

Monthly Fee: $ ______________________ for ______________________ Months

Initial Fee is for services rendered from: _____/_____/_____ to _____/_____/_____

First Monthly fee is due: _____/_____/_____

Are any of the above charges covered by any other insurance company? ☐ Yes ☐ No

If “Yes”, please attach your Explanation of Benefits (EOB) form or a Predetermination form.

Completed by: ____ Date: ____________________

Dental Office

1023904Mktg-RWDSU Local 386