

Automatic Orthodontia Request Form



This form is to be completed for any participant that wants to receive automatic reimbursement for orthodontia expenses. Payments are issued at the beginning of each month for which services are still being provided. If participating in automatic reimbursement for these expenses, the benefits debit card cannot be used to pay the provider.

*=Required Fields

Step 1: Participant Information

*Employer Name (Do not abbreviate)

*Employee ID

*Participant Name (First, MI, Last)

 - -

*Social Security Number

Updates or changes to your information can be made by logging into your account at www.discoverybenefits.com.

Step 2: Orthodontia Information

*Start Date of Treatment (mm/dd/yyyy)

*End Date of Treatment (mm/dd/yyyy)

*Person Receiving Orthodontic Services/Treatment	*Monthly Cost of Treatment
	\$
	\$
	\$

*Total Monthly Reimbursement Request

*Please select only one

<input type="checkbox"/>	Contract Attached: I have attached a copy of the contract or payment plan for each qualifying dependent for which orthodontic services are being provided. Please skip Step 2a.
<input type="checkbox"/>	Orthodontist Signature: My orthodontist has completed and signed Step 2a.
<input type="checkbox"/>	Stop Automatic Orthodontia: I have previously enrolled in automatic reimbursement and request that it be stopped effective _____ (mm/dd/yyyy).

Step 2a: Orthodontist Certification

I, _____ certify the information provided on this form is accurate and that services are being provided to the specified individuals through the dates provided in box A and box B. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

*Orthodontist Signature

*Date

Step 3: Participant Certification

To the best of my knowledge the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Discovery Benefits, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441 which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Discovery Benefits. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

By submitting this form I certify the above.