AXISPLUS BENEFITS

Orthodontic Contractual Agreement

_____ *(service provider's name) hereby certifies the expenses described below, for qualified health care services, will be incurred by the claimant pursuant to a contract and continuous amount stated herein.*

To be considered for reimbursement, the following must be completed:

PATIENT NAME: _____

DESCRIPTION OF SERVICE:

_____

DATES OF SERVICE DURING THE CURRENT YEAR:

_____

AMOUNT INCURRED DURING THE CURRENT YEAR:_____

TOTAL CHARGE FOR COMPLETED SERVICES:

_____

I certify the above information to be true and correct.

SIGNATURE: _____ DATE: _____

(provider or representative)

PROVIDER'S TAX ID NUMBER:_____

Employee Certification and Release for Reimbursement

PAYMENT WILL BE MADE IN:

Monthly scheduled amounts of OR *Annual lump sum amount of $*_____

*$*_____ *per month*

From: _____/_____/_____ *To*: _____/_____/_____

☐ Check here if receiving a pre-payment discount

REIMBURSEMENT METHOD: ☐ *Debit Card* ☐ *Check/Direct Deposit*

EMPLOYEE NAME:_____ SSN:_____-_____-_____

EMPLOYER NAME:_____

I hereby authorize release of payment though my Flexible Spending Account. To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction.

SIGNATURE: _____ DATE: _____