FAX: 585-389-7003

Paychex Employee Services: 877-244-1771
Representatives available Monday – Friday
8:00 a.m. – 8:00 p.m. ET

Submit or view claims **ONLINE:** http://www.paychexflex.com

MAIL: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000

Orthodontia Services (FSA) Reimbursement Claim Form

EMPLOYEE INFORMATION (print)

Employee Name ____ Company Name ____

Employee Telephone Number (_____)________- ___________

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

Did you pay for orthodontia in full?

- ☐ **Yes** –Please submit the itemized bill showing that the payment was made and the date it was paid.
- ☐ **No** - Please have the provider complete the **Certification Section** below **AND** check how you would like to be reimbursed.

IF NO – How do you want to be reimbursed? Check one box below:

- ☐ **AUTOMATIC CLAIM PAYMENTS** – I want to receive reimbursement for my monthly payments for the duration of the orthodontia services provided in the certification below.
- ☐ **SUBMIT INDIVIDUAL CLAIMS** – I want to receive reimbursements for my orthodontia services only when I submit a claim for them. *(Paychex will record your orthodontia contract details and process your orthodontia claims within two business days, only for the amounts requested.)*
- ☐ **Debit Card** – I will be using **the FSA Debit Card** and do not want to be reimbursed by monthly check or direct deposit.

CLAIM AUTHORIZATION

Please ensure that the Certification from Orthodontia Provider is completed in full and signed by the provider.

I certify that the information herein is true and correct; that the expenses incurred were for myself, spouse, or dependents; that these expenses are not reimbursable under any other health plan coverage; and that these expenses are eligible under Section 125 of the Internal Revenue Code.

Employee Signature ____ **Date**_________ / ________ / _________

CERTIFICATION FROM ORTHODONTIA PROVIDER (to be completed by provider)

Name of Orthodontia Provider ____

We certify that we are providing orthodontia services for ________________________________ .
Patient's Name

Note: Your payment details must be completed in full and mathematically correct for your claim to be paid out.

Contract Information

Start Date _________________(Date of First Monthly Payment)

_____________ Total Fee (Date Paid _____________)

\- ___________ Initial Fee (Date Paid)

\- ____________ Discount (if applicable)

\- Records Fee (if applicable) (Date Paid ___________)

\- ___________ Insurance (if applicable)

=___________ Remaining Balance ÷ ______________________ = ______________________
total months of service qualified monthly reimbursable amount

Example:

$2,900 Total Dollar Amount of Contract
- $500 Initial Fee
- $0 Discount
- $0 Records Fee
- $0 Insurance
= $2,400 Remaining Balance ÷ 24 = $100

Signature of Orthodontia Provider ____________________________ **Date**_______/_______/ _______

FSA045 02/22