UPMC FlexAdvantage

Stop Automatic Orthodontia Reimbursement Request Form

This form is to be completed for any employee who 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 employee cannot use the benefits debit card to pay the provider.

Step 1: Participant Information

*=Required Fields

*Employer Name (Do not abbreviate.)

*Member ID

*Participant Name (First, MI, Last)

Note: Reimbursements will be sent to the address on file with UPMC Benefit Management Services. If an address change or update is needed, please contact your Human Resources Administrator to update.

Step 2: Orthodontia Information

*Is this form being submitted for a previously denied claim? If neither box is selected, the form will be processed as "no."

☐ Yes ☐ No

Treatment dates

A.
*Start date of treatment (mm/dd/yyyy)

B.
*End date of treatment (mm/dd/yyyy)

*Person receiving orthodontic services/treatment	*Monthly Cost of Treatment
	$
	$
	$

$
*Total Monthly Reimbursement Request

**Please select only one*

	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.**
	Orthodontist Signature: My orthodontist has completed and signed. **Step 2a.**
	Stop Automatic Orthodontia Reimbursement: 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 individual(s) through the dates indicated in Box A and Box B. I understand the purpose of my signature on this form is to eliminate the necessity for the employee to provide receipts for reimbursement purposes.

*Orthodontist Signature

*Date

Step 3: Employee Certification

To the best of my knowledge, the information provided 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 UPMC Benefit Management Services, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit and that, pending approval, reimbursement will begin the first month following the date of my submission.

By submitting this form, I certify the above.

*Employee Signature

*Date

Mail this signed form to:

UPMC Benefit Management Services

PO Box 2784

Fargo ND 58108-2784

Claims Fax: 1-844-361-4700

Email: flexadvantage@upmc.edu

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