Automatic Orthodontia Request Form

This form is to be completed for any consumer 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.

Instructions:

1. Complete all sections of this form.
2. Mail or fax completed form and required documentation (if applicable) to:
   Address: Fidelity Flexible Spending and Reimbursement Accounts Services
   PO Box 2703, Fargo, ND, 58108
   Fax: 1 (855) 810-8223
3. If you have any questions about completing this form, please contact Fidelity Flexible Spending and Reimbursement Accounts Services at (888) 810-6738. We have representatives available Monday-Friday, 8:30 am - Midnight PT.

Step 1: Consumer Information

*Required Fields

*Consumer Name (First, MI, Last)

*Employer Name

*Birth Date (MM/DD/YYYY) / /

*Social Security Number - -

*Phone Number ( ) -

*Permanent Address

Email Address

*City

*State

*Zip Code

Step 2a: Orthodontia Information

Please complete this section for the individual receiving orthodontic services/treatment. If you have multiple individuals receiving treatment, please submit each one on a separate form.

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
	$

**Please select only one*

- ☐ **Contract Attached:** I have attached a copy of the contract or payment plan for the qualifying dependent for which orthodontic services are being provided. **Please skip Step 2b.**
- ☐ **Provider and Consumer Certification:** Step 2b and Step 3 required.
- ☐ **Stop Automatic Orthodontia:** I have previously enrolled in automatic reimbursement and request that it be stopped, effective _____(mm/dd/yyyy).

Step 2b: Consumer Certification

I, _____, certify the information provided on this form is accurate and that services are being provided to the specified individual 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 participant to provide receipts for reimbursement purposes.

*Orthodontist Signature

*Date

Step 3: Consumer 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 Fidelity Flexible Spending and Reimbursement Accounts 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. I acknowledge that this form may be electronically signed and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

*Consumer Signature

*Date