FSA CLAIMS: ORTHODONTIA

Surency FLEX

KOCH

WE MAKE IT EASY TO PAY FOR ORTHODONTIA SERVICES

It sure is easy.

Unlike other expenses where the IRS requires the expense to be incurred before you are reimbursed from your FSA, orthodontia services are treated differently. You may be reimbursed for orthodontia services before the services are provided if you have made the payments ahead of the services in order to receive them. **These orthodontia services are considered incurred when you make the advance payment.** Because of this, we make it easy to receive reimbursement.

CHOOSE YOUR REIMBURSEMENT METHOD

1 – CLAIMS AS INCURRED (LUMP SUM)

Use this method when paying for ALL services at the time treatment begins. Utilize your FSA funds in one of the following ways:

- Swiping your **Surency Flex Benefits Card** as your form of payment with the orthodontist office.
- Submitting a claim on the Surency Flex mobile app.
- Submitting a claim online by visiting **Surency.com/Koch** and logging in to your Member Account.
- Submitting a paper claim to Surency via the attached form.

When submitting a claim, include the following:

- Proof of payment
- An itemized statement of work or receipts indicating the patient (must be you, a spouse, qualifying child or qualifying relative), amount of the services (member responsibility), and date treatment started and anticipated treatment end date.

2 – CLAIMS AS INCURRED (INDIVIDUAL CLAIMS)

You may request reimbursement for the amount of your orthodontia services on an ongoing basis as you incur expenses. Utilize your FSA funds as explained in METHOD 1 above.

3 – MONTHLY REIMBURSEMENTS (RECURRING PAYMENTS)

You may request reimbursement for the monthly cost of ongoing services by selecting the Automatic Orthodontia Request option on the attached form. This method should be utilized only for claims in which a standard monthly payment will be made by you to the orthodontist. For the initial banding fee, please file a claim as in METHOD 1 above.

Note: If you choose this method, you will need to complete a form for each Plan Year and for each qualified dependent. In addition, it is your responsibility to contact Surency if there is a change in the amount of monthly patient responsibility, or the services cease for any reason.

ORTHODONTIA CLAIM FORM

Surency FLEX

KOCH

Last Name, First Name, MI (Please Print) _____

Employer _____

Social Security or Employee ID as appropriate _____

Street Address _____

City, State, ZIP Code _____

☐ Check if NEW ADDRESS

Requesting Reimbursement for:

☐ Claims As Incurred (Lump Sum or Individual Claims) Fill out sections 1 and 3.

☐ Recurring Payments Fill out sections 2 and 3.

Section 1 - Claims as Incurred (Lump Sum) and/or Claims as Incurred (Individual Claims)

Plan Type	Date Medical Care Provided	Merchant/Provider Name	General Medical Expense/Item Description	Name of Person Receiving Service/Product	Medical Mileage	Claim Amount (Amount of your responsibility)
				TOTAL		

Section 2 - Recurring Payments

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

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

Monthly Out of Pocket Expense _____

Person Receiving Orthodontic Services/Treatment _____

Please select only one:

☐ Contract Attached: I have attached a copy of the contract to payment plan for my qualifying dependent for which orthodontic services are being provided. Please skip the Orthodontia Certification section.

☐ Orthodontist Signature: My orthodontist has completed and signed the Orthodontia Certification section below.

☐ Stop Automatic Orthodontia: I have previously enrolled in automatic reimbursement and request that it be stopped effective _____ (mm/dd/yyyy).

Orthodontia Certification (To be completed if Orthodontist Signature box is checked above)

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

Orthodontist Signature _____

Date _____

Section 3 - Member Signature

To the best of my knowledge the provided information is complete and accurate. I certify that the request I am submitting is an eligible expense 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 Surency, 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 Surency. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

Member Signature _____

Date _____

Return completed form back to Surency at email: flex@surency.com - fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773

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