1605 Associates Drive
Suite 101
Dubuque, IA 52002
Phone: (563) 584-4853
Toll-free: 866-682-2993
Fax: (563) 556-5134
FlexProcessing@mahealthcare.com

ORTHODONTIA CLAIM FORM

Employee: _____ Email Address: _____

Employee SSN#: _____ Employer: _____

For each of the accounts, please include documentation in the order you have listed and attach to this claim form. Submit a completed Health Choices Claim Form and a copy of your orthodontic contract. The contract should show the charges, description of services, dates of service (can be a date range), and name of patient. You'll need to submit a claim each plan year.

Orthodontia Provider Information	
Patient Name:	
Patient Birth Date:	☐ **Eligible Dependent** ☐ **Spouse** ☐ **Self**
Amount Remaining on Contract:	**Total Amount Due:**

Additional Information *(optional)*
Please enter any additional information below (down payments, special explanation of services, etc.)

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my reimbursement plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Signature: _____ Date: _____