

Automatic Orthodontia Request Form



This form is to be completed for any account holder 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.

*Required

Step 1: Accountholder Information

*Employer name (do not abbreviate):	*Employee ID:
*Account holder name (first, mi, last):	*Social security number:
*Day telephone:	

Updates or changes to your information can also be made by logging into your account at <http://MyAccounts.hsabank.com>

Step 2: Orthodontia Information

A.	B.	
*Start date of treatment (mm/dd/yyyy)	*End date of treatment (mm/dd/yyyy)	
*Person receiving orthodontic	*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: 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 participant to provide receipts for reimbursement purposes.	
*Orthodontist signature:	*Date:

Step 3: Accountholder 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 HSA Bank, 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.	
*Account holder signature:	*Date:

Return completed form to **HSA Bank, P.O. Box 2744, Fargo, ND 58108-2744**

Questions? Please call the Client Assistance Center at **1-855-731-5213**