ORTHODONTIA CONTRACT

PARTICIPANT INFORMATION *(to be completed by participant)*			
Participant Name			
Employer Name			
Employee Number/ID			
Name of Patient		**Date Treatment Begins**	

ORTHODONTIA SERVICES INFORMATION *(to be completed by orthodontist)*							
Total Cost of Orthodontia Services		$					
Subtractions	Insurance Payments	$					
	Provider Discount	$					
	Initial Payment Amount Due	$			No. of Months		Monthly Payment and Eligible Monthly Reimbursable Amount
Total Remaining Balances		$		/		=	

ADDITIONAL INFORMATION ***(optional)***

Please enter any additional information below. Additional information can include down payments, special explanation of services, etc.

I certify that the expenses for reimbursement requested from my TASC 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 will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return.

This form must be signed by both the Participant and Orthodontia Provider. Forms without both signatures will not be processed.

Signature of Participant	Date
Printed Name of Orthodontic Service Provider	
Signature of Orthodontic Service Provider	Date

Please fax or mail completed forms to:
Total Administrative Services Corporation (TASC) • PO Box 7511 • Madison, WI 53707-7511
Phone: 844-786-3947 • Fax: 877-231-1287