Dental Direct Reimbursement
Orthodontic Treatment Plan Form

This Orthodontic Treatment Plan form is required for reimbursement. The orthodontist needs to complete and sign this form and submit it to our office along with an itemized bill.

Commencement of orthodontic treatment begins the date the braces are placed on your teeth. Orthodontists typically require a down payment and collect the balance of their fees over the duration of the treatment. The down payment may be up to a maximum of 25% of the estimated total treatment charge and will be processed according to your schedule of benefits. The balance of the charges after the down payment is made will be reimbursed monthly by the plan over the period of treatment. A claim must be submitted each month until the treatment ends or coverage terminates, to receive reimbursement.

IMPORTANT: If your orthodontist charges more than 25% of the estimated total treatment charge as the down payment, the amount DR reimburses may differ from what you are actually paying.

For orthodontic claims that began before the effective date of an employee's coverage, the remaining monthly charges will be reimbursed as treatment is received. If the patient paid the entire bill before the effective date of the employee's coverage, no benefits are payable. This is because there are no expenses to be reimbursed after the individual became eligible for benefits.

Patient Information – To Be Completed by the Employee

Employee Name:	**Employer:**
Patient Name:	
Address:	
Telephone #	**Employee SS/Member#:**
Records Date & Charge:	**Date braces placed on teeth:**
Down Payment Charge:	**Date of Down Payment:**
Date treatment is expected to terminate:	
Total charge for treatment plan:	
Monthly maintenance fee:	**Total # of monthly payments:**
Are benefits to be paid to the doctor? ☐ **Yes** ☐ **No** **If yes, provider's W-9 form is required to meet I.R.S. regulations.**	
Employee Signature:	

Information on the Orthodontist

Name:	
Address:	
Fax #:	**E Mail Address:**
Telephone #	**Tax ID #:**
Orthodontist Signature:	**Date:_____/_____/____**

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