

# ORTHODONTIA TREATMENT STATEMENT

An Orthodontia Treatment Statement is necessary in order to determine eligibility of your or your dependent's treatment plan.

Participant's Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_

**Please ask your Orthodontist to complete the following:**

Responsible Party: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Start Date of Treatment \_\_\_\_\_

Estimated Length of Treatment \_\_\_\_\_

Total Cost of Treatment \_\_\_\_\_

Monthly Payment: \_\_\_\_\_

Insurance Coverage \_\_\_\_\_

Down Payment \_\_\_\_\_

\_\_\_\_\_  
Print Name of Attending Provider

\_\_\_\_\_  
Signature of Attending Provider

\_\_\_\_\_  
Date of Signature

In order for the expense referred to on this Orthodontia Treatment Statement to be reimbursed, attach it and the appropriate receipt or Explanation of Benefits from your Dental Insurance Provider, to a completed Reimbursement Request Form. You may submit this documentation to Igoe Administrative Services via:

Email: [flex@goigoe.com](mailto:flex@goigoe.com)  
Fax: 858-777-5424  
U.S.P.S. Mail: Igoe Administrative Services  
P.O. Box 501480  
San Diego, CA 92150-1480