Clear Form

Orthodontia Treatment Statement

Complete this form to meet the requirements to request reimbursement from a Medical Care Reimbursement Account (MCRA) as it relates to you or your federal tax dependent's orthodontic services.

INSTRUCTIONS: INCLUDE RECEIPTS AND DOCUMENTATION WITH THIS REQUEST FORM

1. **Complete** all sections of this form.
2. **Ask** your provider to complete Section B and C of this form.
3. **Attach a** completed Flexible Benefit Plan Reimbursement Request Form and follow the submittal instructions outlined in the "INSTRUCTIONS" section of that document. **Remember to keep original receipts for your records as you may be required to provide documentation directly to the IRS in the event of a personal audit.** All supporting documentation becomes a part of your request and will not be returned to you.
4. **Tip**
   - While the majority of plans reimburse orthodontia related expenses on a monthly basis, specific information regarding reimbursement can be obtained by emailing Igoe Administrative Services at flex@goigoe.com.
5. **Questions?** Please contact Participant Services at flex@goigoe.com, 1-800-633-8818, Opt# 1.

Section A: About You *(All information is REQUIRED. Please print clearly)

Clear Section A

Employer Name

Participant Name	Number of pages	Employee Number (If Applicable)	
Home Address ☐ Please check if this is a change in address	City	State	Zip
E-mail Address		Phone Number	

Section B: Treatment Detail (to be completed by your provider)

Clear Section B

Name of Patient	Provider Name	
Relationship to Participant	Total Cost of Treatment	$
Service Start Date	Monthly Payment	$
Estimated Length of Treatment (number of months)	Down Payment	$

Section C: Provider Acknowledgement *REQUIRED (PLEASE SIGN AND DATE)

I hereby acknowledge that the above listed services meet the requirements of IRC Section 213 (d)(1), that is that medical care was provided to diagnose, cure, mitigate, treat, or prevent a disease or for the purpose of affecting any structure or function of the body. I further acknowledge that the Name of Patient, Provider Name, Relationship to Participant, Service Start Date, Estimated Length of Treatment, Total Cost of Treatment, Monthly Payment, and Down Payment as listed above are correct.

Provider's Signature: Ready To Sign? Click To Print ***Date:*** _____

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IGOE ADMINISTRATIVE SERVICES