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. **If you are unable to attach your form or document to an online or mobile app claim or alert**, you may use one of these secondary options to send your documentation to us. Please note, that Igoe cannot guarantee the security of any documentation provided to use via the below methods while in transit to our organization:
    - Email to flex@goigoe.com
    - Fax to 800-456-9083
    - OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480
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)

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)

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: ____ ***Date:*** ____________________