
HOW TO SUBMIT ORTHODONTIA EXPENSES THROUGH A FLEXIBLE SPENDING ACCOUNT (FSA)

Before determining how much to set aside in a Health Care Flexible Spending Account, you should be aware that not all orthodontia expenses may be reimbursable. PLEASE CAREFULLY consider the following 2 options:

1. ALL EXPENSES PAID “UP FRONT”

Some orthodontists offer a discount on the total bill if all expenses are paid “up front.” The orthodontist will need to determine the amount related to services performed during the first calendar year. Under IRS guidelines, only expenses for services rendered (not the entire amount paid “up front”) qualify as reimbursable through an FSA. In this manner, FSA participation is limited to the plan year in which services begin.

2. MONTHLY PAYMENTS

For individuals who contract with an orthodontist to make monthly payments over the time of treatment, participation in a Health Care FSA is allowed for more than one plan year. The orthodontist will need to allocate the total charges over each calendar year in relation to services performed. You can be reimbursed each plan year only for those expenses incurred during that period.

In order to comply with IRS guidelines for FSA Programs, the following steps should be taken per patient when submitting orthodontia expenses for reimbursement:

- (1) Obtain a payment contract with the orthodontist
- (2) Have your orthodontist complete a “Flexible Spending Account Orthodontia Expenses Worksheet”

IMPORTANT:

The total charges should be separated per calendar year according to services performed during the anticipated length of treatment. For example,

If orthodontia services begin in October, the first year is from October to December. Indicate total expenses incurred during that time as the first year. Indicate total expenses incurred for the next January through December as the second year, and so forth.

- (3) Submit a completed FSA claim form, proof of any payments, and items (1) and (2) to BCA.

NOTE:

Items (1) and (2) need only be submitted with the first Health Care FSA claim form. If monthly payments are contracted, then subsequent FSA claim forms only require proof of payment (i.e., a payment receipt or invoice) indicating the following information:

- (a) the provider’s name, address, and taxpayer identification number (TIN)
- (b) patient’s name
- (c) date of payment

For questions, please contact a Member Specialist at (503) 228-6554 or toll free at 1-800-852-5195

Your Flexible Spending Account is administered by:

BestChoice Administrators, P.O. Box 67230, Portland, Oregon, 97268-1230



FLEXIBLE SPENDING ACCOUNT ORTHODONTIA EXPENSES WORKSHEET

PLEASE INCLUDE THIS WORKSHEET WHEN SUBMITTING YOUR FIRST HEALTH CARE
FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM FOR THESE EXPENSES

EMPLOYEE NAME:	PROVIDER OF SERVICE:
SOCIAL SECURITY NUMBER:	ADDRESS:
EMPLOYER:	PHONE NUMBER:
PATIENT:	TAXPAYER IDENTIFICATION NUMBER (TIN):
PATIENT'S RELATIONSHIP TO EMPLOYEE:	
DATE SERVICES BEGAN:	
ANTICIPATED LENGTH OF TREATMENT:	
ESTIMATED TOTAL CHARGES (Please include copy of signed payment contract): \$	
ESTIMATED CHARGES COVERED BY INSURANCE: \$	INSURANCE CARRIER:

TREATMENT PLAN	INDICATE SERVICES TO BE PROVIDED DURING EACH YEAR
FIRST YEAR - TOTAL AMOUNT OF EXPENSES INCURRED \$ _____	
SECOND YEAR - TOTAL AMOUNT OF EXPENSES INCURRED \$ _____	
THIRD YEAR - TOTAL AMOUNT OF EXPENSES INCURRED (if applicable) \$ _____	
FOURTH YEAR - TOTAL AMOUNT OF EXPENSES INCURRED (if applicable) \$ _____	