(406) 721-2222 or (877) 424-3570
Fax: (406) 523-3149 or (877) 424-3539
www.allegianceflexadvantage.com

ORTHODONTIA SUBMISSION

Reimbursement Options

Monthly Payment Options:

1. Payment Coupon/Bill (most common reimbursement option).

Monthly payments can be reimbursed from your flex account by submitting your monthly billing statement or payment coupon. Documentation should show provider name, month of service and the monthly payment.

2. Orthodontia Contract.

Initial payment and monthly contract amounts may be reimbursed by submitting an Orthodontia Contract (your own or Option 1 on form below). The contract must specify the date the initial payment is due, the length of treatment, and monthly installment amount. When selecting this option, reimbursements can be set-up by Allegiance to pay out automatically each month (if selected on contract). Claim date will be entered as the 25th of the month prior to the month due. Example: If your payment is due for November, the claim will be entered on October 25th.

**Note: Allegiance can only reimburse based on provider contracts, not federal Truth in Lending Statements.*

Lump Sum Payment Option:

If prearranged with your provider, Allegiance will reimburse lump sum payments if the documentation can verify that services are incurred within your Plan Year. (See Option 2 in form below.)

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ORTHODONTIC EXPENSE CONTRACT

EMPLOYER: ____

EMPLOYEE: ______________________________ **Participant ID:** ______________________

PATIENT NAME: ____

Payment Option 1 (please check all that apply)**:** ☐ Initial Payment ☐ Monthly Payment

Services and Fees:
(Please note: Please do not fill out Payment Option 1 if you are planning to pay services in full. See Payment Option 2)

Start Date: ______________ Length of Treatment: ______________

Total Treatment Charges		$ ________________
- Insurance Payment		-($ ________________)
Participant Out-of-Pocket	=	$ ________________
Records Fee		$ ________________
Initial Down Payment		$ ________________
Number of Months		____
Monthly Payment Due		$ ________________

Pre-enter monthly payments: ☐ (payments will be entered on the 25th of each month prior to month due.)

Payment Option 2: ☐ Lump Sum Payment

Orthodontia Charge for your current Flex Plan Year (After insurance portion has been paid)	$ ________________
Flex Plan Year (mm/dd/yy – mm/dd/yy)	________________

In order for Allegiance to process your reimbursement request, please have your provider sign below.

Orthodontist's Name: ____
(please print)

Orthodontist Signature: ____ Date: ____________
(Required)