FAX: 585-389-7003

Submit or view claims **ONLINE:** **https://benefits.paychex.com**

Paychex Employee Services: 877-244-1771, available 24/7

FOR OFFICE USE ONLY
Docket # ____________

PAYCHEX®

Flexible Spending Account (FSA) Reimbursement Claim
Orthodontia Services

EMPLOYEE INFORMATION (print)

Employee Name ______________________________ Company Name ______________________________

Social Security Number ______________________________ Employee Telephone Number (___) ________-________

E-mail Address |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Visit **https://benefits.paychex.com** at any time to submit claims **ONLINE** or learn the status of your claim.

All claim reimbursements will be processed within 2 business days upon receipt of the completed claim form and all supporting documentation.

INSTRUCTIONS CHECKLIST:

- ☐ **Sign your claim form** and fax it to the number noted above. Retain a copy for your records.
- ☐ Make sure your orthodontia services provider signs the form as indicated below.
- ☐ If you prefer, mail your claim to: Paychex, Inc., FSA Claims, PO Box 3000, Henrietta, NY 14467-3000.

CLAIM INFORMATION

Paychex can process your orthodontia claim either by individual monthly payment or automatically each month throughout the length of your contract according to your monthly payment amount.

If you want Paychex to process your claim by individual monthly payment, submit the **Unreimbursed Medical Expenses** claim form along with a copy of your orthodontia services contract.

If you want your orthodontia claims to be processed automatically each month, ensure that the **Certification from Orthodontia Provider** is completed in full.

I certify that the information herein is true and correct; that the expenses incurred were for myself, spouse, or dependents; that these expenses are not reimbursable under any other health plan coverage; and that these expenses are eligible under Section 125 of the Internal Revenue Code.

Employee Signature ______________________________ **Date** ________ / ________ / ________

CERTIFICATION FROM ORTHODONTIA PROVIDER

We certify that we are providing orthodontia services for ______________________________ , age ________.
Patient's Name Patient's Age

Contract Information

Name of Orthodontia Provider ______________________________

Total Amount of Contract ____________ Start Date ____________ Estimated Months of Service ____________

Initial Fee ____________ Records Fee ____________ Insurance Payment ____________

Total Monthly Payments of $ ____________ for ____________ months.

Signature of Orthodontia Provider ______________________________ **Date** ________ / ________ / ________

If you have more claims, please complete additional Reimbursement Claim forms.