INNOVA Benefit Services

CERTIFICATION FORM: Orthodontic Expenses

Participant Information *(Please Print)*

Employer's Name:	
Employee's Name	Patient's Name:

Orthodontia Expense Certification *(Attach this form and any receipts to a completed claim form.)*

This form is intended to aid in the submission of orthodontic expenses. From this certification we can also set up ongoing monthly reimbursements or auto-substantiation. This eliminates the need to submit a claim each month or to send in substantiation each month for a card swipe.

Please have the service provider complete this form.

Patient Name:		
Treatment Start Date:		
Total Treatment Fee:		A
Insurance Payment:		B
Total Out-of-Pocket Expense:		C = (A - B)
Amount for Up Front Work:		D
Remaining Balance:		E = (C - D)
Number of Months of Treatment:		F
Amount of Monthly Reimbursement :		G = (E / F)

Provider Certification

Provider's Signature:	Date:
Provider's Name: (Please Print)	

Please submit your completed certification form along with your completed Claim Form.

INNOVA Benefit Services
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