



2600 West 49<sup>th</sup> Street  
 P.O. Box 7406  
 Sioux Falls, SD 57117-7406

**FLEX**

Phone: 1-800-325-5598  
 Fax: 1-605-336-0270

### Orthodontics Claim Reimbursement Form

Employee Name: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_  
 Insured ID #: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_

Relationship to Employee:  
 Spouse: \_\_\_\_\_  
 Child: \_\_\_\_\_

Provider Information:  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

The above named patient is receiving treatment for the following medical/dental condition(s):

\_\_\_\_\_

\_\_\_\_\_

Services being rendered by the above-listed provider are designed to cure, mitigate, treat or prevent this specific medical/dental condition(s); the treatment is not primarily cosmetic in nature.

Provider Signature \_\_\_\_\_

Payment	Date	Amount
Intl Pymnt		
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**TREATMENT PLAN:**

Total months of treatment: \_\_\_\_\_ Months  
 Total cost of treatment: \$ \_\_\_\_\_  
 Portion Covered by Insurance: \$ \_\_\_\_\_ ( \_\_\_\_\_ )  
 Total cost to member: \$ \_\_\_\_\_

Excluding interest paid or finance charges:

Member Signature: \_\_\_\_\_

Mail completed form to: Phone: 1-800-325-5598  
**DAKOTACARE FLEX** Fax: 1-605-336-0270  
 2600 West 49<sup>th</sup> Street Email: flex@dakotacare.com  
 PO Box 7406  
 Sioux Falls, SD 57117-7406