

Note to Patient: Have your orthodontist complete and sign this form. Then return the completed form to Aetna with your Flexible Spending Account claim submission.

Note to Orthodontist: Please photocopy this form onto your letterhead. Then complete the information, and sign and date at the bottom of this form.

The following information regarding my orthodontia supports my request for reimbursement from my Aetna Health Care Flexible Spending Account.

Name of Orthodontia Provider _____

Address _____

National Provider Identifier _____ Phone Number _____

Patient's Name _____

Total fee for the treatment \$ _____ Estimated insurance \$ _____

Down payment amount \$ _____ Length/Duration of treatment _____

Date of banding ____ / ____ / ____

Brief description of services rendered (e.g., Orthodontic Treatment) _____

Orthodontia Provider Signature

____ / ____ / ____
Date

FSA Participant Signature

____ / ____ / ____
Date