

Orthodontic Care Expense Receipt (must submit with completed Claim Form)

Fax to: **608 831 4790**
 Mail to: **Employee Benefits Corporation**, PO Box 44347, Madison WI 53744-4347
 Phone support: **800 346 2126**, 608 831 8445, M - F 8:00 - 5:00 Central
 E-mail support: **participantservices@ebcflex.com**

Account Holder Information

Last 4 Digits of Social Security or Identification Number
 (Required)

Last Name First Name

E-mail Address (we do not share your e-mail address) Employer

Orthodontist Information and Charges

Orthodontist Name		Orthodontist's Tax ID#	Patient's Name
Initial Fee	\$		
	Dollar Amount	Date of Payment (mm-dd-yyyy)	
Records Fee	\$		
	Dollar Amount	Date of Payment (mm-dd-yyyy)	
Monthly Installment	\$		
	Dollar Amount	Date of Payment (mm-dd-yyyy)	
Other	\$		
	Dollar Amount	Date of Payment (mm-dd-yyyy)	Other Charges

Orthodontist Signature Date (mm-dd-yyyy)

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Orthodontist Signature Date (mm-dd-yyyy)

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