2600 West 49th Street
Sioux Falls, SD 57105-6575 **FLEX**

Phone: 1-800-325-5598
Fax: 1-605-336-0270
Email: flex@dakotacare.com

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

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: ______________________

Date: ______________________

Payment	Date	Amount
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Mail completed form to:
DAKOTACARE *FLEX*
2600 West 49th Street
Sioux Falls, SD 57105-6575

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