

**CORPORATE BENEFIT SERVICES OF AMERICA, INC. (CBSA)  
ORTHODONTIA RECEIPTS**

***IN ORDER TO PROCESS THIS CLAIM, ALL OF THE FOLLOWING INFORMATION MUST BE COMPLETED. (One Per Family Member Per Month.)***

**THE FOLLOWING INFORMATION MUST BE GIVEN BY THE ORTHODONTIST'S OFFICE:**

Date of Service	Dependent's Name	Type of Service	Amount of Charge
_____	_____	_____	_____

**Provider: *I certify the above charges, procedures, and service dates are valid.***

\_\_\_\_\_ Date \_\_\_\_\_  
(Orthodontist's Signature/Stamp)

**FLEX PARTICIPANT: I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE, AND THAT THESE EXPENSES WILL NOT BE SUBMITTED UNDER ANY OTHER INSURANCE. I REALIZE ALL INFORMATION ABOVE MUST BE PROVIDED FOR THIS CLAIM TO BE PROCESSED.**

\_\_\_\_\_ Date \_\_\_\_\_  
Flex Participant's Signature

\_\_\_\_\_

Print Name

\_\_\_\_\_

Flex Participant's Social Security Number

\_\_\_\_\_

Flex Participant's Employer