ORTHODONTIA CONTRACT

Submit this completed form via one of the following methods:	Online Support Request	Fax	Mail
	Log onto your online account at https://cda.basiconline.com/ and attach the completed form via Support Request	(269) 327-0716	BASIC PO Box 6278 Monona, WI 53716

EMPLOYER INFORMATION

Client/Employer Name:		**Client/Employer ID #:**	
Division: (If applicable)			

INDIVIDUAL/PARTICIPANT INFORMATION

First Name:		**MI:**		**Last Name:**	
Benefits ID: (12 digit)		**Email Address:**			
Primary Phone #:		**Mobile Phone #:**			
Primary Address:	**Address Line 1:**			**Apt:**	
	Address Line 2:				
	City:				
	State:		**ZIP/Postal Code:**	**+4**	
Patient Name:		**Date Treatment Begins:**			

All fields required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.

ORTHODONTIA SERVICE INFORMATION

Total Cost of Orthodontia Services: $			
Subtractions:			
Insurance Payments: $			
Provider Discount: $			
Initial Payment Amount Due: $			
Total Remaining Balances: $		Divided by # of Months	
Monthly Payment and Eligible Monthly Reimbursable Amount: $			

ADDITIONAL INFORMATION: (***Optional***)

Please enter any additional information below. Additional information can include down payments, special explanation of services etc.

AUTHORIZATION REQUIRED ON PAGE 2

ORTHODONTIA
CONTRACT

AUTHORIZATION

I certify that the expenses for reimbursement requested from my BASIC accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my reimbursement plans. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return.

This form must be signed by both the Consumer and Orthodontia Provider. Forms without both signatures will not be processed.

Participant Signature: _____ **Date:** _____

Participant Name: _____
(Please Print)

Orthodontic Service Provider Signature: _____ **Date:** _____

Orthodontic Service Provider Name: _____
(Please Print)

For assistance: call toll-free 800-372-3539
Have your form, employer name, and your 12 digit Benefits ID# ready.
Full resources available on our web page: www.basiconline.com/CDA