



Wellmark BlueCross BlueShield of Iowa
 Wellmark BlueCross BlueShield of South Dakota
 Independent Licensees of the Blue Cross and Blue Shield Association

ORTHODONTIC PAYMENT FORM

If you would like Wellmark Flexible Benefits Department to automatically process your monthly orthodontic payments for payment from your flexible benefits account, complete this form, along with section one of the enclosed claim form, and have your provider sign below.

Participant Name				Participant Social Security Number - -	
Participant's Employer					
Patient Name				Group Plan Year	
Orthodontic Treatment fee \$		Initial/Down Payment \$		Total Unpaid Balance to be Paid in Monthly Installments \$	
Start Date of Contract / /		End Date of Contract / /		Number of Months	
				Monthly Payment \$	
Month	Year	Installment Amount	Month	Year	Installment Amount
January			July		
February			August		
March			September		
April			October		
May			November		
June			December		
July			January		
August			February		
September			March		
October			April		
November			May		
December			June		
January			July		
February			August		
March			September		
April			October		
May			November		
June			December		

Signature of Orthodontist _____

Signature of Participant _____

Plan Administrator Use Only

Contract Setup
Employee Memo

Contract Done
Employee Memo