

IBIS 125 Advantage Plan Orthodontic Payment Form

Return to: 105/125 Department
800.258.1415
515.286.4244 fax

Iowa Bankers Insurance & Services, Inc
PO Box 6210
Johnston, IA 50131

Employer Name/Location	Billing/Routing Number
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Below are the instructions for processing orthodontic claims. Attached to this document are: the statement of services from my orthodontist, a copy of the orthodontic contract for down payment, a copy of the EOB from my dental insurance showing coverage and a receipt for any pre-payment of services rendered.

Employee	Social Security Number
Dental Insurance Company (if applicable)	Group Plan Name
Patient	Date Appliance Placed
Ortho Treatment Fee	Initial Down Payment
Unpaid Balance	
Orthodontic Contract Start Date	Orthodontic Contract End Date

I have insurance coverage through _____ effective date _____.

- Please reimburse for my initial down payment. Attached are the contract and the receipt for down payment and/or statement of services, dates and payments made.
- Please reimburse the balance of my contract (amount not paid by insurance) or the remaining amount of my contract for plan year 20___. Attached are the contract, EOB, and the receipt for payment and/or statement of services, dates and payment made.
- Please reimburse my monthly contract amount shown below. Attached is my contract for services.
(After any insurance payment)

Month	Installment amount	Insurance Payment	Total to reimburse
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Signature of Employee _____ Date _____

