

PERSONAL CHOICE ACCOUNT

Flexible Benefits Administration

Proof of Payment Statement

Date _____

Patients Name _____

Amount Paid _____ for orthodontic treatment.

Received by: _____

Dentist Name and Address: _____

Dentist Signature: _____

Flex participants may **have the dental office** complete this statement and include it with a Reimbursement Request form for submission under the Personal Choice Account.