

# PERSONAL CHOICE ACCOUNT

Flexible Benefits Administration

## Proof of Payment Statement

Date: \_\_\_\_\_

Patients Name: \_\_\_\_\_

Amount Paid \$ \_\_\_\_\_ for orthodontic treatment.

Received by: \_\_\_\_\_

Dentist Name and Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.