Allegiance® a Cigna Company

ORTHODONTIA SUBMISSION FORM

Faxed and mailed claims may take longer to process than electronic claims and will not appear in your account until reimbursement occurs. For quick and easy processing, please login online to submit your claim. If you have not received reimbursement within two weeks, please contact an Allegiance representative at 877-424-3570.

If you would like future payments directly deposited into your bank account, include a voided check with this form or sign up on the Allegiance website.

Reimbursement Options

Monthly Payment Options:

1. **Payment Coupon/Bill** (most common reimbursement option).

   Monthly payments can be reimbursed from your flex account by submitting your monthly billing statement or payment coupon. Documentation should show provider name, month of service and the monthly payment.

2. **Orthodontia Contract**

   Initial payment and monthly contract amounts may be reimbursed by submitting an Orthodontia Contract (your own or Option 1 in form on reverse side). The contract must specify the date the initial payment is due, the length of treatment, and monthly installment amount. When selecting this option, reimbursements can be set-up by Allegiance to pay out automatically each month (if selected on contract). Claim date will be entered as the 25th of the month prior to the month due. Example: If your payment is due for November, the claim will be entered on October 25th.

   Note: Allegiance can only reimburse based on provider contracts, not federal Truth in Lending Statements.* *****Orthodontia contracts have to be renewed and submitted each plan year*

Lump Sum Payment Option:

If prearranged with your provider, Allegiance will reimburse lump sum payments if the documentation can verify that services are incurred and paid within your Plan Year. (See Option 2 in form on reverse side)

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Orthodontic Expense Contract

Employer: _____

Employee: _____ Participant ID: _____

Patient Name: _____

Payment Option 1 (please check all that apply):

☐ Initial Payment ☐ Monthly Payment (payments will be entered on the 25th of each month prior to month due)

Service and Fees:
(Please note: Please do not fill out Payment Option 1 if you are planning to pay services in full. SeePayment Option 2)

Start Date: _____ Length of Treatment: _____

Total Treatment Charges: $_____

–Insurance Payment: – ($ _____)

Participant Out-of-Pocket : = $ _____

Records Fee: $ _____

Initial Down Payment: $ _____

Number of Months: _____

Monthly Payment Due: $ _____

Payment Option 2 ☐ Lump Sum Payment

Orthodontia Charge for your current Flex Plan Year: $ _____

(After insurance portion has been paid)

Flex Plan Year (mm/dd/yy - mm/dd/yy) _____

Only lump sum payment amount made in the current plan year above $_____ Date Paid _____

In order for Allegiance to process your reimbursement request, please have your provider sign below.

Orthodontist's Name: _____
(please print)

Orthodontist's Signature: _____ Date: _____
(required)

Ortho Contract 2019