



Healthcare Claim Form

Please clearly all information

File a Claim by Mail:
 Nova Healthcare Administrators
 an Independent Health Company
 511 Farber Lakes Drive
 Buffalo, NY 14221
 Fax: (716) 774-8092
 Online: myflexpend.com

Your Information

Name: _____ Employer Name: _____
 Address: _____ Phone: _____
 City, State: _____ Zip Code: _____
 Last 4 digits of your Social Security Number: _____ Please check here if this is a new address

Please indicate if you have the following types of coverage*:
 Medical coverage? Yes No
 Dental coverage? Yes No
 Vision coverage? Yes No
 *if yes, please be sure to provide an explanation of benefits (EOB) or co-payment receipt

Healthcare Expenses

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one) <input type="checkbox"/> Chiropractic <input type="checkbox"/> Co-Pay <input type="checkbox"/> Dental <input type="checkbox"/> Ortho <input type="checkbox"/> Prescription <input type="checkbox"/> Psych/Therapist <input type="checkbox"/> Vision <input type="checkbox"/> Other: _____			

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
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Total Request	
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Certification

I certify that the expenses for which I am requesting reimbursement were incurred for service or supplies by my eligible dependents or me under the plan. These services were furnished on or after the effective date of my employee spending account. I understand the reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my Healthcare Account. I understand reimbursement will be made in accordance with the guidelines set by the Internal Revenue Service and the provisions of the plan. I accept all responsibility for the proper treatment of benefits under this plan with respect to eligibility, income tax reporting and liability.

Employee Signature (required): _____ Date: _____



Healthcare Claim Form

How to file a claim

File a Claim

- Return completed Healthcare Claim Form with documentation
Mail: Nova Healthcare Administrators, an Independent Health Company, 511 Farber Lakes Drive, Buffalo, NY 14221
If you elect to mail your information it is advised that you keep a copy for your records.
Please do not staple receipts to your claim form.
Fax: (716) 774-8092
Online: myflexspend.com
- Please pick only one delivery method - do not fax and mail.
- Claims must be received by Nova five full business days prior to your scheduled reimbursement date.

Complete the Healthcare Claim Form

Complete ALL employee information. Using approved documentation please complete patient name, provider name, date(s) of service, type of service and amount of claim.

Eligible FSA Expenses

Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. These are explained in IRS Publication 502. A medicine or drug will be a qualified medical expense for FSA purposes only if the medicine or drug: requires a prescription, is available without a prescription (an over-the-counter medicine or drug) and you get a prescription for it, or is insulin. You cannot receive distributions from your FSA for any amount paid for health insurance premiums, long-term care coverage or expenses, or amounts covered under another health plan.

Eligible HRA Expenses

Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. These are explained in IRS Publication 502. A medicine or drug will be a qualified medical expense for HRA purposes only if the medicine or drug: requires a prescription, is available without a prescription (an over-the-counter medicine or drug) and you get a prescription for it, or is insulin. You can receive distributions from your HRA for amounts paid for health insurance premiums, long-term care coverage, or amounts not covered under another health plan. For more information see IRS Publication 969.

Qualified Documentation

- Itemized receipts include all of the necessary information required for reimbursement (provider name and address, patient name, itemized charges, date(s) of service and type of service.)
- An Explanation of Benefits (EOB) is the preferred form of documentation to submit for reimbursement, especially if a portion of your expense is covered by medical, dental or vision coverage.
- You may submit a maximum of 4 expenses on a single claim form.