Health Care Claim Form

How to file a claim

File a Claim

- Return completed Health Care Claim Form with documentation
  Mail: Nova Healthcare Administrators, PO Box 1534, Buffalo, NY 14231
  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: https://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 the necessary information required for reimbursement (provider name and address, patient name, itemized charges, date(s) of service, type of service, and member and insurance liability.)

- 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 four expenses on a single claim form.

*Final plan design is determined by the employer.

Health Care Claim Form

Please clearly PRINT all information

File a Claim by Mail:
Nova Healthcare Administrators
PO Box 1534
Buffalo, NY 14231
Fax: (716) 774-8092
Online: https://myflexspend.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

*To prevent claim denial, please be sure to provide an Explanation of Benefits (EOB) or itemized receipt.

Healthcare Expenses

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
			◯ FSA ◯ HRA
Type of Service (check one)	◯ Chiropractic ◯ Copay ◯ Dental ◯ Ortho ◯ Prescription ◯ Psych/Therapist ◯ Vision ◯ Other: ________		

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
			◯ FSA ◯ HRA
Type of Service (check one)	◯ Chiropractic ◯ Copay ◯ Dental ◯ Ortho ◯ Prescription ◯ Psych/Therapist ◯ Vision ◯ Other: ________		

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
			◯ FSA ◯ HRA
Type of Service (check one)	◯ Chiropractic ◯ Copay ◯ Dental ◯ Ortho ◯ Prescription ◯ Psych/Therapist ◯ Vision ◯ Other: ________		

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
			◯ FSA ◯ HRA
Type of Service (check one)	◯ Chiropractic ◯ Copay ◯ Dental ◯ Ortho ◯ Prescription ◯ Psych/Therapist ◯ Vision ◯ Other: ________		

Total Request	

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: __________________