Qualified Transportation Claim Form

How to file a claim

File a Claim

- Return completed Qualified Transportation 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: 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 Qualified Transportation Claim Form

Complete **ALL** employee information. Using approved documentation please complete provider name, description of service, dates of service, and amount of claim.

Eligible Expenses

Qualified transportation may include:

- Transportation in a commuter highway vehicle if such transportation is in connection with travel between the employee's residence and place of employment
- A transit pass,
- Qualified parking,
- Any qualified bicycle commuting reimbursement.

Please confirm your plan benefits with your employer.

Qualified Documentation

- Itemized receipts include all of the necessary information required for reimbursement (provider name, description of service, service dates (begin and end), and amount paid).

- If your provider does not provide authorized receipts you must ask the provider to sign the reimbursement form. Claims cannot be reimbursed without proper documentation or provider certification.

- You may submit a maximum of 5 expenses on a single claim form.

Qualified Transportation 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: 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

Qualified Transportation Expenses

Provider Name	Dates of Service (MMDDYY – MMDDYY)	Type of Service (fill in circle)	Total Charges
		○ Commuter Vehicle ○ Transit Pass ○ Qualified Parking ○ Bicycle Reimbursement	

Provider Name	Dates of Service (MMDDYY – MMDDYY)	Type of Service (fill in circle)	Total Charges
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Total Request	

Certification

I certify that the expenses for which I am requesting reimbursement were incurred for service or supplies by 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 I am 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 Qualified Transportation 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: ____________________