

Lifestyle Spending Account Claim Form

File a Claim

- Return completed Lifestyle Spending Account Claim Form with an itemized receipt.
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 Claim Form

Complete **ALL** sections in full. Please include copies of paid itemized receipts. All paid receipts require the date of service, description of services rendered, name of individual or organization providing service. Cancelled checks are not acceptable in lieu of a paid receipt.

Section 1 – Member Information

Name of Member Receiving Service _____

Member ID _____

Section 2 – Vendor Information

Date(s) of Service _____

Name of Individual or Organization Providing Service _____

Address of Service Provider _____

Type of Service Received _____

Total Amount of Request (*receipt must be attached*) _____

Section 3 – Employee Information

Name of Employee _____

Employee Phone Number _____ ☐ mobile ☐ home ☐ work

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. I understand reimbursement will be made in accordance with the guidelines set by the plan.

Employee Signature (required): _____ Date: _____