Pet Reimbursement Account Claim Form

File a Claim

- Return completed Pet Reimbursement Account Claim Form with an itemized receipt.
  Online: https://myflexspend.com
  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
- Please pick only one delivery method — do not upload and mail.
- Claims received less than five business days prior to your scheduled reimbursement date will be processed with the next reimbursement cycle.

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 – Vendor Information

Date(s) of Service or Date of Order _____

Vendor Name _____

Vendor Address _____

Vendor Website *(for online purchases)* _____

Product or Service Purchased _____

_____

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

Section 2 – Employee Information

Employee Name _____ Last 4 digits of your SSN _____

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: _____