Adoption Assistance Claim Form

How to file a claim

File a Claim

- Return completed Adoption Assistance 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 Adoption Assistance Claim Form

Complete ALL employee information.

Eligible Expenses

Qualified expenses include adoption fees, court fess, attorney fees and related travel costs. This does not include expenses incurred in a surrogacy arrangement or in connection with the adoption of a step-child. For the adoption of a child who is not a U.S. citizen or resident, adoption assistance funds can only be used once the adoption becomes final. For the adoption of a child who is a US citizen or resident, when a qualified expense is incurred before the year in which the adoption becomes final, the credit is allowed for the following tax year. The adoption assistance funds can be claimed even if the adoption never becomes final.

Qualified Documentation

- Please include a copy of the adoption agency bill or detailed court document with each reimbursement request.

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

Adoption 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

Reasonable and Acceptable Adoption Fee Claims

Dates of Service Incurred	Name of Service Provider	Expense Description	Name of Dependent(s)	Net Amount

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Total Amount Requested	

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 Adoption 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: _____