nova®
An Independent Health company

Medical Claim Form

To be completed by cardholder/employee.
*Please clearly **PRINT** all information*

File a Claim by Mail:
Nova Healthcare Administrators
P. O. Box 211428, Eagan, MN 55121
Fax: (716) 932-5098

1	Group #:	Employer:		Policy Holder/Subscriber ID:
2	If applicable, apply unreimbursed expenses to Flex Account ☐ Yes ☐ No	Employee Status: ☐ Active ☐ Retired ☐ COBRA ☐ Terminated		
3	Name of Cardholder/Employee	☐ Married ☐ Single	☐ Male ☐ Female Birthdate:	Daytime Phone #:
4	Address of Cardholder/Employee: Number & Street	City	State	Zip
5	For dependent claims, complete lines 5, 6, 7	Name of Dependent: Birthdate:	☐ Married ☐ Single	☐ Male ☐ Female Relationship:
6		Employer of Dependent *(if any)*:	Address of Employer:	
7		School where Dependent is enrolled:		Expected Date of Graduation:
8	Are you or any of your family members covered under another group health plan or Medicare? ☐ Yes ☐ No	If yes, (a) Insurance Company: (b) Employer: (c) Policy # or ID #:		
9	Is claim based on accident/injury? ☐ Yes ☐ No If yes, date of accident/injury:	Did accident/injury happen while working? ☐ Yes ☐ No		Auto accident/injury? ☐ Yes ☐ No
10	If so, advise how, when, where accident/injury occurred:			Is legal counsel being sought? ☐ Yes ☐ No

ASSIGNMENT: I hereby authorize payment directly to the hospital, physician or dentist herein named of the group benefits payable to me. I understand I am financially responsible for charges not covered by this assignment.

Cardholder/Employee Signature Date Signed

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Nova Healthcare Administrators, Inc. or its authorized representatives, to obtain any information which may be necessary to determine benefits payable under the benefit plan administered by Nova Healthcare Administrators, Inc. A photocopy of this authorization will be valid.

Patient's Signature *(or parent if the patient is a minor)* Date Signed

COMPLETE ALL CLAIMS: I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse the Plan Sponsor or its representatives to the extent of any overpayment in excess of the amounts payable under the group plan:

Cardholder/Employee Signature Date Signed

Please complete this form and be sure to include the following items:

- Itemized bill
- Patient name
- Date of service
- Diagnosis
- Procedure code (CPT)
- Provider's Tax ID

Questions? Please call Nova's Customer Service department using the phone number on your ID Card.