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: 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 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 the necessary information required for reimbursement (provider name, description of service, service dates (begin and end), and amount paid).

- You may submit a maximum of five 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: 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

Qualified Transportation Expenses

Provider Name	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one)	◯ Commuter Vehicle ◯ Transit Pass	◯ Qualified Parking ◯ Bicycle Reimbursement

Provider Name	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one)	◯ Commuter Vehicle ◯ Transit Pass	◯ Qualified Parking ◯ Bicycle Reimbursement

Provider Name	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one)	◯ Commuter Vehicle ◯ Transit Pass	◯ Qualified Parking ◯ Bicycle Reimbursement

Provider Name	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one)	◯ Commuter Vehicle ◯ Transit Pass	◯ Qualified Parking ◯ Bicycle Reimbursement

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: ____________________