Healthcare Claim Form

How to file a claim

File a Claim

- Return completed Healthcare Claim Form with documentation
  Mail: Nova Healthcare Administrators, an Independent Health Company, 511 Farber Lakes Drive, Buffalo, NY 14221
  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 fax and mail.

- Claims must be received by Nova five full business days prior to your scheduled reimbursement date.

Complete the Healthcare Claim Form

Complete **ALL** employee information. Using approved documentation please complete patient name, provider name, date(s) of service, type of service and amount of claim.

Eligible FSA Expenses

An FSA can help offset out-of-pocket expenses on healthcare products and services for you and your dependents. This encompasses a large variety of eligible items including some dental expenses, as defined in Section 213(d) of the IRS tax code. You can view a listing of eligible expenses in IRS Publication 502. We advise that you keep a copy of all receipts submitted for reimbursement. Generally, credit card statements and cancelled checks will not provide enough detail to serve as qualified documentation for reimbursement.

Eligible HRA Expenses

Eligible HRA expenses include those that are primarily for diagnosis, cure, mitigation or prevention of disease as outlined in IRS Publication 502. Expenses must be for a qualifying account holder or dependent, fall within the HRA plan year, and must not have otherwise been reimbursed. For questions on specific expenses which may or may not be reimbursable, please refer to your benefit plan documents.

Qualified Documentation

- Itemized receipts include all of the necessary information required for reimbursement (provider name and address, patient name, itemized charges, date(s) of service, and type of service, as well as member and insurance liability amounts, when applicable.)

- An Explanation of Benefits (EOB) is the preferred form of documentation to submit for reimbursement, especially if a portion of your expense is covered by medical, dental or vision coverage.

- You may submit a maximum of 4 expenses on a single claim form.

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Please clearly **PRINT** all information

File a Claim by Mail:
Nova Healthcare Administrators
an Independent Health Company
511 Farber Lakes Drive
Buffalo, NY 14221
Fax: (716) 774-8092

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

Please indicate if you have the following types of coverage*: Medical coverage? ☐ Yes ☐ No
Dental coverage? ☐ Yes ☐ No Vision coverage? ☐ Yes ☐ No
*To prevent claim denial, please be sure to provide an explanation of benefits (EOB) or itemized receipt.

Healthcare Expenses

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one)	☐Chiropractic ☐Co-Pay ☐Dental ☐Ortho ☐Prescription ☐Psych/Therapist ☐Vision ☐Other: ________		

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one)	☐Chiropractic ☐Co-Pay ☐Dental ☐Ortho ☐Prescription ☐Psych/Therapist ☐Vision ☐Other: ________		

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one)	☐Chiropractic ☐Co-Pay ☐Dental ☐Ortho ☐Prescription ☐Psych/Therapist ☐Vision ☐Other: ________		

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
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Total Request	

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 Healthcare 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: ____________________