nova
An Independent Health company

Healthcare Claim Form

Please clearly 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
Online: 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

Please indicate if you have the following types of coverage*: Medical coverage? ☐ Yes ☐ No
Dental coverage? ☐ Yes ☐ No Vision coverage? ☐ Yes ☐ No
*if yes, please be sure to provide an explanation of benefits (EOB) or co-payment 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
Type of Service (check one)	☐Chiropractic ☐Co-Pay ☐Dental ☐Ortho ☐Prescription ☐Psych/Therapist ☐Vision ☐Other: ______		

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: ______________