

Company Name: \_\_\_\_\_

**Please mail claims to:**

Nova Healthcare Administrators, Inc.  
an Independent Health Company  
Attn: FSA Administration  
511 Farber Lakes Drive  
Buffalo, NY 14221

Local Phone: 716.505.8509

Toll Free: 800.264.9115

Fax: 716.774.8092

**A – Instructions**

- ✓ Complete sections B, C, D, and E (where applicable)
- ✓ If expense is covered by insurance, submit to appropriate carrier
- ✓ Attach explanation of benefit (EOB) from the insurance carrier or co-pay receipts
- ✓ Itemized bills should include the following:  
\*Provider name & address \*Patient name \*Itemized charges \*Date of service \*Type of service
- ✓ Cancelled checks, cash register receipts, non-itemized receipts, and balance due bills are not acceptable proof of expenses
- ✓ Be sure that your company name appears at the top of this form
- ✓ **All claims must be received in office five business days prior to your scheduled reimbursement date**
- ✓ For over-the-counter drugs, circle the eligible item(s) on your receipt. Cash register receipts are acceptable for over-the-counter drugs

**B – Employee Information**

Name:	Social Security:
Address:	Phone:
City, State:	Zip:
If this is a new address, please check here <input type="checkbox"/>	

**C – Healthcare Expenses (FSA / HRA)**

Please indicate if you have the following types of coverage:

Dental coverage? Yes ☐ No ☐ Medical coverage? Yes ☐ No ☐  
Vision coverage? Yes ☐ No ☐  
\*if yes, please be sure to provide an explanation of benefits (EOB) or co-payment receipt

Patient Name	Provider (Doctor/Dentist/Pharmacy)	Date(s) Range for Service	Total Charges

Total Healthcare Reimbursement Request - \$ \_\_\_\_\_

**D – Dependent Care (daycare) Expenses (FSA only)**

Child(ren) Name(s)	Provider	Federal ID Number	Date of Service	Total Charges

Total Day Care Reimbursement Request - \$ \_\_\_\_\_

**E – Certification**

I certify that the expenses for which I am requesting reimbursement meet all the following conditions listed below:

- ✓ They were incurred for service or supplies by my eligible dependents or me under the plan.
- ✓ They were for services or supplies furnished on or after the effective date of my employee spending account.
- ✓ I have not been reimbursed for these expenses in any other way.

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 my individual income tax return any of the expenses reimbursed through my Healthcare Account or my Dependent Care Account. I understand that 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
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