Health Savings Account Reimbursement Form

How to file a claim

File a Claim

- Return completed Health Savings Account (HSA) 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
  Email: flex@novahealthcare.com
  Online: myflexspend.com
- Please pick one delivery method – for example, do not fax and mail
- Claims must be received by Nova five business days prior to your scheduled reimbursement date.

Complete the HSA Reimbursement Form

Complete ALL employee information. Using approved documentation please complete, patient name, provider name, date(s) of service, and amount of total reimbursement requested.

Eligible HSA Expenses

An HSA 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 the cost of diagnosis, cure, mitigation, treatment or prevention of disease, defined in IRS publication 502 (Medical and Dental expenses). We advise that you keep a copy of all receipts submitted for reimbursement. Generally, credit card statements and canceled checks will not provide enough detail to serve as qualified documentation for reimbursement.

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 expense is covered by medical, dental, or vision coverage.

HSA Claim Form

Please clearly PRINT all information

File a Claim by Mail:
Nova Healthcare Administrators
P.O. Box 1534, Buffalo, NY 14221
Fax: (716) 774-8092

Primary Account Holder Information

Last Name	First Name	Employer Name	
Street Address	City	State	Zip
Email Address	Daytime Phone	SSN	

Reimbursement Information

Provider Name	Date of Expense
Patient Name	Total Reimbursement*

Type of Expense: ☐ Medical ☐ Prescription ☐ Dental ☐ Vision

*If the requested reimbursement amount is higher than your available balance, we will only process the reimbursement up to the available balance in the account. **An account closure fee is held in reserve from your account and may not be used for reimbursement.**

Reimbursement Method

☐ Option 1 – Check

This method is slower. Please allow 7-10 business days to receive your check. **A $25.00 fee will be deducted from your health savings account (HSA).**

☐ Option 2 – Use the verified electronic funds transfer (EFT) account you already tied to my HSA.

(If and EFT is not on file, a check will be sent and a $25.00 fee may apply. Please allow 7-10 business days for the check to arrive.)

☐ Option 3 – Transfer the funds to the following account.

(**Note:** An email address is required for EFT.)

Account Type: ☐ Checking ☐ Savings

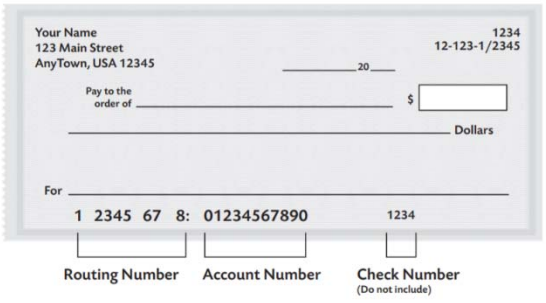
Financial Institution: _____

City/State: _____

Routing Number: _____

Account Number: _____

Form must be accompanied by a voided or actual check.



Reimbursement Information

By signing below, I authorize Nova Healthcare Administrators, Inc. to reimburse me from my health savings account (HSA) for my expense in the manner specified above and I represent that the information I provided in this request is true and complete.

Name (please print)	Signature	Date

Reimbursement requests can also be made online at myflexspend.com or using the NovaFlex app.