Dependent Care Claim Form

How to file a claim

File a Claim

- Return completed Dependent Care 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: 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 Dependent Care Claim Form

Complete ALL employee information. Using approved documentation please complete provider name, dependent name, dates of service, type of service and amount of claim. A provider signature is not required however it can be added in lieu of a receipt as proof of service.

Eligible Expenses

Eligible dependent care expenses are those expenses you must pay for the care of a dependent so that you (and your spouse) can work. The care may be provided in your home or at a licensed center outside of your home. If the care is in your home, services cannot be provided by another child of yours under the age of 19, your spouse, or other dependents.

Qualified Documentation

- Itemized receipts include all of the necessary information required for reimbursement (provider name, provider contact information, dependent name, service dates (begin and end), a description of services and amount paid).
- If your dependent care provider does not provide authorized receipts you must ask the provider to sign the reimbursement form. Dependent care claims cannot be reimbursed without proper documentation or provider certification.
- You may submit a maximum of 4 expenses on a single claim form.

Why is Documentation Important

- The IRS has provided strict requirements stating that expenses reimbursed through a FSA must be substantiated using itemized receipt or provider certification. All supporting documentation must include provider name, provider contact information, dependent name, service dates (begin and end), a description of services and amount paid.
- Per IRS regulations, dependent care claims submitted without required proof of expense cannot be approved for reimbursement. Please note that claims submitted for future dates of service may be denied and will need to be resubmitted after the end date of services provided.
- Additionally, claims not authorized for reimbursement through a dependent care account by the IRS will also be denied.

Ineligible Expenses

Only dependent care expenses that enable you and your spouse to work are eligible. Dependent care expenses not eligible for reimbursement under current IRS regulations include: activity fees, assisted living, boarding school, clothing, daycare for children over age 12*, field trips, food (if billed separately), kindergarten, late payment fees, nursing home, overnight camp, summer school, tuition and tutoring. For a complete list of eligible expenses please visit www.novahealthcare.com/Members/MemberResources/FSA-HSAEligibilityList

Dependent Care Claim Form

Please clearly PRINT all information

nova® An Independent Health company

File a Claim by Mail:
Nova Healthcare Administrators
PO Box 1534
Buffalo, NY 14231
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

Dependent Care Expenses

Dependent Name	Provider Name	Type of Service (fill in circle)	Total Charges
		○ Child Care ○ Summer Day Camp ○ Before/After School ○ Au Pair ○ Adult Day Care ○ Preschool	
Dates of Service	Provider Tax ID or SSN	Signature of provider in lieu of itemized receipt:	

Dependent Name	Provider Name	Type of Service (fill in circle)	Total Charges
		○ Child Care ○ Summer Day Camp ○ Before/After School ○ Au Pair ○ Adult Day Care ○ Preschool	
Dates of Service	Provider Tax ID or SSN	Signature of provider in lieu of itemized receipt:	

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Dependent Name	Provider Name	Type of Service (fill in circle)	Total Charges
		○ Child Care ○ Summer Day Camp ○ Before/After School ○ Au Pair ○ Adult Day Care ○ Preschool	
Dates of Service	Provider Tax ID or SSN	Signature of provider in lieu of itemized receipt:	

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 Dependent Care 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: ______________