General Claim Form

Company Name: **Southern Tier Environments for Living-STEL**

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: 1-800-264-9115
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
- ✓ Cancelled checks, cash register receipts, non-itemized receipts, and balance due bills alone are not acceptable proof of expenses. They must be accompanied by itemized bills.
- ✓ Itemized bills should include the following:
  ***Provider name & address** ***Patient name** ***Itemized charges** ***Date of service** ***Type of service**
- ✓ **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. A prescription or copy of the label is required.

B – Employee Information

Name:	Social Security:
Address:	Phone:
City, State:	Zip:
If this is a new address, please check here ☐	

C – Healthcare Expenses (FSA / HRA) (Including Individual Insurance Premium)

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

Patient Name	Provider/Individual Insurer (Doctor/Dentist/Pharmacy/ Carrier)	Date(s) Range for Service	Total Charges	Amount Paid with FSA Card	Benefit Amount Requested	
					FSA Only OR FSA 50% (employee $)	HRA 50% (STEL $)
Sub Totals:						

Total Healthcare/Insurance Reimbursement Request (Add above Sub Totals) - $_____

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