Medicare Advantage
Dental Receipt Reimbursement

This form is to be used for reimbursement of dental services.
Please mail this Reimbursement Form and itemized bill and paid receipt to*:

Nova Healthcare Administrators, an Independent Health Company
PO Box 1534
Buffalo, NY 14231
Fax: (716) 774-8092

Or you may visit myflexspend.com to submit your completed reimbursement form and upload your receipts of payment.

*All paid receipts require the date of service, name of Dental Provider and amount paid. Cancelled checks are not acceptable in lieu of a paid receipt. Please keep a copy of all documents for your records, as copies submitted with your request will not be returned. Please do not staple receipts to your claim form. You must submit your claim to us within 12 months of the date you received the service.

Section 1 – Member Information (please print)

Member Name _____

Address _____

Independent Health ID Number (refer to member ID card) _____

Phone Number ( ) _____

Group Number _____

Section 2 – Dental Provider Information (please print)

Dental Provider Name _____

Dental Provider Address _____

Total Amount of Request (receipt must be attached) $_____

Dental Provider NPI or Tax ID_____

Section 3 – Member Signature

I certify that the expenses for which I am requesting reimbursement were incurred for service or supplies by me under the plan.
These services were furnished on or after the effective date of my plan. 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 I am 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.

Signature _____ Date _____

Please allow four to six weeks for reimbursement.
If you have questions, please call (716) 505-8566 or 877-268-3799 (TTY: 711);
Monday – Friday, 8 a.m. – 6 p.m.

nova®
An Independent Health company

Services provided by a dental provider or other practitioner who has been precluded by Medicare or debarred from receiving federal funds, except for emergency and urgently needed services, will not be covered.

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