



How to Submit a Claim

We offer four easy ways for you to access your healthcare account funds. **For fastest results, we encourage you to submit your claim with CYC Mobile.**

Payment Card

1. If your account included a payment card, you can use it to directly pay for services at eligible healthcare and locations such as doctor's offices, hospitals, and pharmacies.
2. **Save your receipts!** When you swipe the card, a claim is created for you and eliminates the need for you to fill out a claim form. However, documentation may still be required. If a receipt is needed, you will be notified by email or letter within two weeks of your payment card swipe. You can also review if your claim requires receipts online by logging into your online account.

Online Claim Submission

1. Log in at www.connectyourcare.com.
2. Follow the instructions on the main page to enter a new claim. Enter the requested information about your claim and continue through the screens to submit the claim and required documentation.

CYC Mobile Claim Submission

1. Download CYC Mobile to your Android, iOS, or Windows or Windows device. Log in using your existing ConnectYourCare website username and password.
2. Click "Add new claim" from the main screen. Enter the requested information about your claim and continue through the screens to confirm and submit the claim. You can even take a picture of your receipts and upload according to IRS documentation requirements or for record-keeping purposes.

Paper Claim Submission

1. If you didn't use your payment card and are unable to access the Internet, complete the Manual Claim Form.
2. Fax it with itemized receipts or other documentation to (443) 681-4602. When you fax the Manual Claim Form and supporting documentation, there is no need to follow up with a hard copy in the mail. Remember to keep the original claim form and supporting documents for your records.
3. If you choose to mail your claim form and documentation instead of faxing, the address is:
Claims Department
P.O. Box 622317
Orlando, FL 32862-2317



Manual Claim Form

Use this form to submit your claims for reimbursement of eligible expenses paid out of pocket that have not already been submitted.

- Do not use this form if expenses were already paid with your healthcare payment card.
- Do not use this form if you already submitted this claim online.
- Complete all entries on this submission form. Please print or type.
- Sign and date this form.
- Fax or mail it, along with the required documentation, to the claims department. (See submission instructions below.)

Personal Information	
Name of Employer	
Employee Name (last name, first name)	Social Security Number

Documentation Required
<p>You must submit documentation with this form. Documentation must include the patient's name, description of service, date of service and amount charged. Cancelled checks, credit card receipts or balance forward statements are not acceptable. Examples of acceptable documentation include a copy of the Explanation of Benefits (EOB) from your insurance company, an itemized statement from a provider, or an itemized pharmacy receipt (if applicable to your plan).</p>

Claim Details					
Date of Service	Patient's Name	Relationship to Employee	Name of Provider	Description of Service	Amount Requested
Total					\$

Authorization and Certification
<p>Read carefully: This claim will not be processed without your signature.</p> <p>I certify that these expenses have been incurred by me or by my eligible spouse or dependent.* The expenses have not been reimbursed and are not reimbursable under any other plan, such as a group medical plan, individual policy, or spouse's or dependent's plan. I understand that any amount reimbursed may not be used to claim any federal income tax deduction or credit on my or my spouse's or my dependent's income tax return. I understand that it is my responsibility to determine whether distributions are for qualified expenses and for any tax consequences that may occur. *If I am participating in an HRA, I certify that any medical expenses have been incurred by me or by my eligible spouse or dependent covered by my medical plan.</p>
<p>_____</p> <p>Signature Date</p>

Submission Instructions	
<p>For fastest results, fax to: (443) 681-4602</p>	<p>Or mail to: Claims Department P.O. Box 622317 Orlando, FL 32862-2317</p>
<p>If you have any questions, please contact Customer Service.</p>	