How to Submit a Claim

We offer four easy ways for you to access your health care account funds. **For fastest results, we encourage you to submit your claim using the myCYC mobile app or payment card.**

Payment Card

1. If your account includes a payment card, you can use it to directly pay for services directly at eligible health care and locations such as doctor's offices, hospitals, and pharmacies.

2. **Save your documentation!** 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 documentation by logging into your online account.

Mobile App Claim Submission

1. Download the **myCYC mobile app** from your app store. Log in using your existing ConnectYourCare website username and password.

2. Click "Make a payment" from the main screen. Enter the requested information about your claim and continue through the screens to take a picture of and upload your documentation. Once documentation is uploaded to your claim, click confirm and then submit.

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.

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 the form along with copies of all required documentation to (443) 681-4602. When you fax the Manual Claim Form and copies of your supporting documentation, there is no need to follow up by sending 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 health care payment card.
- Do not use this form if you already submitted this claim using the mobile app or 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)	Last 4 Digits of Social Security Number

Documentation Required

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 documentation 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).

Claim Details

Date of Service	Patient's Name*	Relationship to Employee	Name of Provider	Description of Service	Amount Requested
				Total	$ 0

Authorization and Certification

Read carefully: This claim will not be processed without your signature.

I certify that these expenses have been incurred by me or by my eligible spouse or dependent* as defined by my Plan and relevant IRS guidelines. 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.

Signature _____ Date _____

Submission Instructions

For fastest results, fax to: (443) 681-4602	Or mail to: **Claims Department** P.O. Box 622317 Orlando, FL 32862-2317

If you have any questions, please contact **Customer Service.**

* Patient/dependent must be eligible for reimbursement under your plan and relevant IRS guidelines.