



## How to Submit a Claim for Health Savings Accounts

We offer several easy ways for you to access your Health Savings Account (HSA) funds. **For fastest results, we encourage you to submit your claim with CYC Mobile.**

### Payment Card

1. Use your healthcare payment card to pay for services at eligible healthcare locations such as doctor's offices, hospitals, and pharmacies. The card deducts the funds directly from your account.
2. Always save your receipts; the IRS may require them at tax time.

### Online Claim Submission

1. Log in at [www.connectyourcare.com](http://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 confirm and submit the claim.

### CYC Mobile Claim Submission

1. Download CYC Mobile to your Android, iOS, 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 them 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 HSA Withdrawal Form.
2. Fax it to (443) 681-4601.
3. If you choose to mail your claim form instead of faxing, the address is:  
**Claims Department**  
P.O. Box 622337  
Orlando, FL 32862-2337



## HSA Withdrawal 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 to the claims department. (See submission instructions below.)

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

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

Authorization and Certification
<p><b><i>Read carefully: This claim will not be processed without your signature.</i></b></p> <p>I certify that these expenses have been incurred by me, my spouse or my eligible dependent. The expenses have not been reimbursed and are not reimbursable under any other plan, such as an individual policy or my 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 income tax return.</p>
<div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 60%; border-top: 1px solid black; margin-top: 10px;">Signature</div> <div style="width: 35%; border-top: 1px solid black; margin-top: 10px;">Date</div> </div>

Submission Instructions
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%; padding-right: 10px;">           For fastest results, fax to: (443) 681-4601         </div> <div style="width: 50%;">           Or mail to: <b>Claims Department</b>            P.O. Box 622337            Orlando, FL 32862-2337         </div> </div>

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