How to Submit a Claim for Dependent Care Accounts

We offer three easy ways for you to access your Dependent Care Account funds. **For fastest results, we encourage you to submit your claim with CYC Mobile.**

For Dependent Care Accounts, you may only receive reimbursements for services already incurred. An expense is incurred when a service is received, not when a bill is paid. Even though your service provider may require payment at the beginning of the service period, you cannot request reimbursement until after the service is provided.

Online Claim Submission

1. **Collect Documentation:** Collect an itemized statement from your dependent care provider containing the required information (Provider's Name, Dependent's Name, Service Period, Payment Amount and Care Being Provided). Or, ask your provider to complete the Provider Information section on the Dependent Care Account Claim and Provider Documentation Form (included in this document).

2. **Submit Claim and Documentation:** Log into your online account at www.connectyourcare.com. 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 via fax or upload.

Mobile Claim Submission

1. **Collect Documentation:** Collect an itemized statement from your dependent care provider containing the required information (Provider's Name, Dependent's Name, Service Period, Payment Amount and Care Being Provided). Or, as your provider to complete the Provider Information section on the Dependent Care Account Claim and Provider Documentation Form (included in this document)

2. **Submit Claim and Documentation:** Log into the CYC Mobile App, available for Android, iOS, and Windows devices, with the same username and password as your online account. Select "Add a New Claim" and follow the instructions to enter a claim and submit documentation by taking a picture or uploading a saved image.

Paper Claim Submission

1. **Collect Documentation:** Ask your provider to complete the Provider Information section on the form as documentation. Or, collect an itemized statement from your dependent care provider containing the required information (Provider's Name, Dependent's Name, Service Period, Payment Amount and Care Being Provided).

2. **Submit Claim and Documentation:** Fax the form with receipts and required documentation to (443) 681-4601. When you fax the 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.

   If you choose to mail your form and documentation instead of faxing, the address is:

   Claims Department
   P.O. Box 622337
   Orlando, FL 32862-2337

Dependent Care Account Claim and Provider Documentation Form

Use this form to submit your claims for reimbursement of eligible dependent care expenses.

- You may only receive reimbursements for services already incurred. An expense is incurred when a service is received, not when a bill is paid. Even though your service provider may require payment at the beginning of the service period, you cannot request reimbursement until after the service is provided.
- Complete all entries on this submission form. Please print or type.
- Sign and date this form.
- Fax or mail it, along with any additional required documentation, to the claims department. (See submission instructions below).

Personal Information	
Name of Employer	Claim # (if claim has already been entered online)
Employee Name (last name, first name)	Social Security Number

Provider Certification or Documentation Required

You may either have your provider complete this section or you may submit documentation with this form. If submitting documentation, attach a copy of an itemized statement from your caregiver. The caregiver's statement must include the caregiver's tax ID, dates of service and amount charged. Cancelled checks, credit card receipts or balance forward statements are not acceptable.

Provider Name:_____ Provider Address: _____

Provider Certifies: • I am a qualified care provider. • I provided care as noted below and charged the amount listed.

_____ _____

Provider Signature Date

Claim Details

Service Start Date	Service End Date	Dependent's Name	Relationship to Employee	Name of Provider	Description of Service	Amount Requested
					Total	$

Authorization and Certification

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

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. I further certify that dependent care expenses were incurred for the purpose of allowing me (and my spouse, if applicable) to be gainfully employed.

_____ _____

Employee Signature Date

Submission Instructions	
For fastest results, fax to: (443) 681-4601	Or mail to: **Claims Department** P.O. Box 622337 Orlando, FL 32862-2337
If you have any questions, please contact **Customer Service.**	