



Sharecare FMLA/Disability Submission Portal Instructions

1. Navigate to portal website:

<https://myplatform.hds.sharecare.com/submission-tools/ui/patient?clientId=NC058F>

- a. **If you bookmark the tool, please be sure to edit your bookmark and copy and paste the above URL.*

2. Select Start Request

Welcome to your FMLA/Disability Forms request service.

- 1 **Verify your identity:** Ensure you have a valid driver's license or state ID card handy. [Learn more about ID requirements.](#)
- 2 **Fee may apply:** If applicable, we'll inform you about any charges.
- 3 **For patients and authorized representatives:** This service is designed for individual patients authorized representatives. [Find out more.](#)
- 4 **For organizations:** If you're requesting for an organization, please follow our [third-party guidelines.](#)

Ready to begin? Click 'Start Request' to proceed securely.

Start Request

3. Select Yes, I am the patient

Are you the patient? (Required)

Yes, I am the patient.

No, I am not the patient.

Previous
Next

4. Enter First and Last name

What is your full name? (Required)

First *	Middle	Last *
John ×		Doe ×

Previous
Next



5. Enter date of birth

6. Enter your email address

- a. Confirm email address
- b. If you would like to receive status notification, please Select - I consent to receive status notification emails about the progress of this request. Note, Sharecare will never share your email address or use it for any other purpose.

7. Enter cell phone number

- a. Confirm cell phone number

8. Upload Forms document

- a. Drag and drop files to upload
 - i. Or
- b. Click select files to search your device or file

Please note: Document must be PDF format and do not encrypt, or password protect the file.

9. Enter Practice or clinic information

- a. Facility Name
- b. Street Address
- c. City
- d. State
- e. Zip Code

10. Select Recipient of Forms

- a. Patient (yourself)
- b. A family member, caregiver
 - i. If selected, enter Recipients Name



- c. A third party, such as an employer or insurance company
 - i. If selected, enter Recipients Name
- 11. Select preferred Delivery Method
 - a. Secure Email
 - i. Enter email address
 - 1. Patients email address with be auto populated.
 - b. Mail
 - i. Enter mailing address
 - c. Fax
 - i. Enter Fax number
- 12. Enter Recipients phone number
- 13. Enter any additional information
- 14. Sign for your request
- 15. Rate your experience.
- 16. Enter additional feedback and Select Submit Request

95 % Completed

We would welcome any additional feedback you might have on the use of this form.

(This is not required, but we value your opinion!)

Use Shift + Enter to add a line break

Previous
Submit Request

Note: Refreshing this page or using your browser's back button will clear all the data you have entered.