network health | Supported by Employee Benefits Corporation

Pick Your Perks 2021 Reimbursement Claim Form Instructions

For quicker reimbursement, file online via your Network Health member portal. Log in at login.networkhealth.com and click the My Benefits button.

To request reimbursement manually, read these instructions thoroughly, complete the form on the next page, and return by mail.

1. **Network Health Member Information**
   - Complete this section in full
   - Please be sure to include your 9-digit Network Health member ID; this is required to process your claim
2. **Expense Information**
   - Please complete one line for each receipt you are submitting for reimbursement
   - Submit additional forms if you have more than five receipts to submit
3. **Direct Deposit**
   - Complete this section in full. If you have already submitted your banking information to the Pick Your Perks program, you do not need to do so again
4. **Required Documentation**
   - Refer to the table below for the required documentation for each eligible expense; this documentation must be included, or your claim cannot be processed.
   - Itemized receipts for all claims must include/display the following.
     - Name of provider or retailer
     - Date(s) of service
     - Service description or list of purchased items
     - Expense amount
     - Note: Credit card receipts without the above information are not adequate documentation
5. **Submit Your Claim**
   - Retain original copies for your records and mail the completed form and documentation to
     Employee Benefits Corporation
     PO Box 44347
     Madison, WI 53744-4347

Benefit Type	Required Documentation
Dental	Itemized receipt
Vision hardware	Itemized receipt
Non-emergency transportation	No receipt required. Must use plan-approved vendor, Aryv
Home delivered meals	Itemized receipt -AND- Proof of inpatient, outpatient or SNF stay (such as EOB or bill) -OR- Doctor's note attesting to qualifying condition Must use plan-approved vendor, Mom's Meals
Acupuncture	Itemized receipt
Massage	Receipt -AND- Prescription from a medical provider
Over-the-counter (OTC) items	Itemized receipt
Nutritional/dietary counseling	Itemized receipt

For more details about eligible and excluded expenses, refer to your Evidence of Coverage at networkhealth.com/medicare/additional-benefits or view plan materials in your Network Health member portal.

Questions? Call 888-831-4753

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Network Health Member Information

Last Name _____ First Name _____

Phone Number _____ Network Health Member ID | | | | | | | | | | |

Expense Information (Submit additional forms if you have more than five receipts.)

Date of Service	Provider or Retailer Name	Claim Amount
		$
		$
		$
		$
		$

Direct Deposit (Skip this step if you are already enrolled in direct deposit for your Pick Your Perks benefit.)

Bank Name	Account #	9-digit Routing #	Account Type
			☐Checking ☐Savings

☐ I do not have direct deposit. Please mail me a check, which takes longer than direct deposit.

Important Certifications Regarding This Claim

By submitting this form, I understand, agree with, and certify all of the following statements: (1.) Everything I entered on this form is complete and true. (2.) I must submit only eligible expenses for reimbursement, including those expenses that may require a discussion with my provider (dual-eligible OTC). Eligible expenses are defined by my plan. These expenses have not been, nor will be, reimbursed by any other benefit plan. (3.) Employee Benefits Corporation (EBC), a partner of Network Health, may obtain and use "protected health information" regarding coverage or benefits under the plan and disclose it to an insurer or other provider of services related to the plan. Any such use or disclosure will be only for purposes of the plan and only for as long as EBC is providing services to the plan. (4.) I have included direct deposit information above, EBC is hereby authorized to send reimbursements (and appropriate adjusting entries) for this claim and future claims electronically or by any other commercially accepted method to my designated account at the financial institution above. This authorization will remain in effect until Employee Benefits Corporation has received written notification from me of its termination in such time and in such manner as to provide Employee Benefits Corporation a reasonable opportunity to act on it. EBC is not responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of my financial institution in depositing funds to my account. I must notify EBC immediately of any changes to my direct deposit information.

Communication Preferences (Skip this step if you have completed this on a previous claim submission.)

To verify or update your contact information, contact Network Health.

☐ I prefer to receive communications by mail.
☐ I prefer to continue to receive communications by email.

Mail this form and the required documentation to:
Employee Benefits Corporation, PO Box 44347, Madison, WI 53744-4347

Network Health Medicare Advantage Plans include MSA, HMO and PPO plans with a Medicare contract. Enrollment in Network Health Medicare Advantage Plans depends on contract renewal. H5215_2958-03-0621_M Accepted 08082021