network health | Supported by Employee Benefits Corporation

2024 Pick Your Perks Claim Form

For quicker reimbursement, file your claims securely online via your Network Health portal. Log in at login.networkhealth.com and click *My Benefits*.

Complete the following form and mail it with **copies** of your documentation to Employee Benefits Corporation (EBC). **EBC must receive all claims and documentation within 120 days of service or your item's purchase.** A separate claim form is required for each individual Network Health Member, even spouses.

Find more details about eligible expenses in your Evidence of Coverage at networkhealth.com/medicare/plan-materials **or** view your plan materials in your Network Health member portal. Everyday items such as over-the-counter allergy medicine, cold and flu relief, dental floss, and more are eligible for reimbursement!

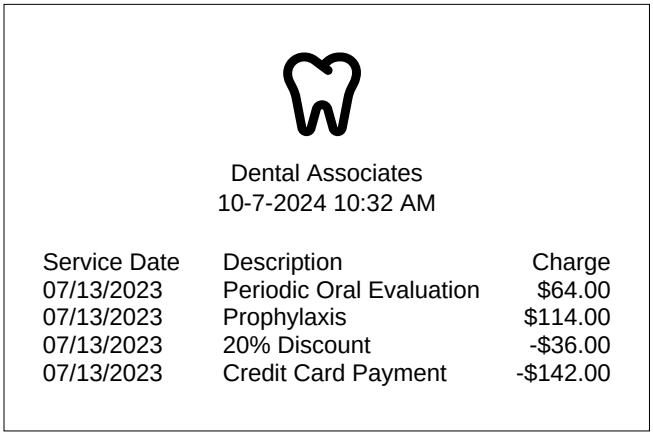
Mail Your Claim To:

Employee Benefits Corporation
PO Box 44347
Madison, WI 53744-4347

Required Documentation

Refer to the table below for the required documentation for each eligible expense. Copies of your documentation are required, or your claim cannot be processed. Credit card receipts and/or statements are not adequate documentation as they don't include a service description or date of service. Itemized receipts for all claims must include/display the following.

- Name of provider or retailer
- Date of service
- Service description or list of purchased items
- Cost of the product or service



Dental Associates
10-7-2024 10:32 AM

Service Date	Description	Charge
07/13/2023	Periodic Oral Evaluation	$64.00
07/13/2023	Prophylaxis	$114.00
07/13/2023	20% Discount	-$36.00
07/13/2023	Credit Card Payment	-$142.00

Itemized Receipt Sample

Benefit Type	Required Documentation
Acupuncture	Itemized receipt
Dental	Itemized receipt
Home delivered meals from Mom's Meals	Itemized receipt from Mom's Meals -AND- proof of qualifying stay -OR- doctor's note attesting to qualifying condition
Massage	Receipt -AND- prescription from a medical provider
Non-emergency transportation from Aryv	No receipt required, must use plan-approved vendor, Aryv
Non-prescription over-the-counter (OTC) items	Itemized receipt
Nutritional/dietary counseling	Itemized receipt
Personal training (up to 4 visits annually with a $225 annual limit)	Itemized receipt
Vision hardware	Itemized receipt

Questions? Call 888-831-4753

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Network Health Member Information

Last Name _____ First Name _____

Network Health Member ID (Required for processing claims) | | | | | | | | | | |

Expense Information

Complete one line for each receipt you are submitting for reimbursement. Submit additional forms if you have more than five receipts. Check the box in the Documentation Provided column to confirm you have included documentation. Claims and documentation must be submitted within **120 days** of service or your item's purchase. **Mail claims to Employee Benefits Corporation at PO Box 44347, Madison, WI 53744-4347.**

Date of Service	Provider or Retailer Name	Claim Amount	Documentation Provided
		$	☐
		$	☐
		$	☐
		$	☐
		$	☐

Direct Deposit

☐ Use the direct deposit information already on file from my last claim submission.
☐ Add/Update my direct deposit using the following information.

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

☐ Mail me a check, which takes up to **three weeks**.

Important Certifications Regarding This Claim

By submitting this form, I understand, agree with, and certify all 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) 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 EBC has received written notification from me of its termination in such time and in such manner as to provide EBC 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 (To verify or update your contact information, contact Network Health.)

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