



For quicker reimbursement, file your claims securely online via your Network Health portal. Log in at login.networkhealth.com and select the *Pick Your Perks* quick access button.

Complete the following form and submit 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. Your service does not need to be paid in full to submit your claim for reimbursement. You may request reimbursement as payments are made to ensure claims are received within the 120-day deadline.

View more details about eligible expenses in your Evidence of Coverage at networkhealth.com/medicare/plan-materials or 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.

Submit Claim Online for Fast and Secure Processing.

1. Log in at login.networkhealth.com
2. Select the *Pick Your Perks* quick access button
3. Complete the form, upload documentation and submit

If you need to mail your claim form and required documentation, send it to:

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

Required Documentation

Copies of your documentation are required to process your claim. Credit card receipts or statements are not acceptable as they may omit necessary information. Itemized invoices or receipts for all claims must 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
10-7-2027 10:32 AM

Service Date	Description	Charge
08/13/2027	Periodic Oral Evaluation	\$64.00
08/13/2027	Prophylaxis	\$114.00
08/13/2027	20% Discount	-\$36.00
08/13/2027	Credit Card Payment	-\$142.00

Itemized Receipt Sample

A complete overview of the documentation required for each benefit type can be found in your online account at login.networkhealth.com.

Questions? Call 888-831-4753

Network Health Member Information

Complete this section for the **member's account** that incurred the expense.

Member First Name _____ Member Last Name _____

Network Health Member ID (Required) Date of Birth _____

Expense Information

Complete one line for each invoice or receipt you submit for reimbursement. Please use additional forms if you submit more than five documents and check the box in the Documentation Provided column to confirm they are included. **Claims and documentation must be received within 120 days of service or item's purchase.**

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

View a complete list of eligible expenses in your online account at login.networkhealth.com.

Examples of expenses not covered by Pick Your Perks include: Medical services (prescriptions, copayments, lab work, hospital or ER visits); vision exams or eyewear warranties; hearing aid services or supplies; chiropractic services; dental insurance premiums or memberships; diabetic supplies; personal hygiene or household cleaning items; CBD or hemp products; purchases made outside the United States; coupons, cash-back offers, reward points or discounts.

Reimbursement

To set up or manage direct deposit, log in at login.networkhealth.com and select the *Pick Your Perks* quick access button. Claims are processed **within 5 business days** of receipt and reimbursed via direct deposit. If direct deposit is not set up, a **check will be mailed which could take up to 21 business days**.

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.

Communication Preferences

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

- ☐ I prefer to continue receiving communications by email.
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