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Employee Benefits Corporation

Pick Your Perks 2021 Reimbursement Claim Form Instructions

To request reimbursement electronically, visit your Network Health portal at login.networkhealth.com.

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

1. **Member Information.** Complete the section in full.
2. **Expense Information.** Submit a max of two expenses per form. For more than two expenses, submit additional forms. When purchasing multiple over-the-counter items, submit an entire receipt/purchase as one expense.

   A. Benefit Type. Enter the benefit type listed for your eligible expense. For more details about your eligible expenses, refer to your plan materials in your Network Health member portal.

Benefit Type	Required Documentation	Notes
Dental	Itemized receipt	Cosmetic dentistry, orthodontia and services covered by Medicare are excluded
Vision hardware	Itemized receipt	Cosmetic items, warranties and Lasik are excluded
Non-emergency transportation with Aryv	None	Must use plan-approved vendor, Aryv
Home-delivered meals with Mom's 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 Qualifying conditions include cancer, diabetes, heart disease, high blood pressure, lung disease, and COPD and osteoporosis
Acupuncture	Itemized receipt	Must be provided by a licensed/certified professional
Massage	Receipt and prescription	Must be provided by a licensed/certified professional
Over-the-counter (OTC) items	Itemized receipt	Items must be on the plan's approved list
Nutritional/dietary counseling	Itemized receipt	Must be provided by a licensed/certified professional Meal plans, lab work and allergy tests are excluded

   B. Claim Details. Enter the provider or retailer name, claim amount, and service start and end dates.

3. **Direct Deposit.** Complete the section in full, unless you've already submitted your banking information to the Pick Your Perks program.
4. **Required Documentation.** Refer to the table for the required documentation for your benefit type. Claims without the required documentation will not be reimbursed. Itemized receipts for all claims must include/display:
   - Name of provider or retailer
   - Date(s) of service or purchase
   - Service description or list of purchased items
   - Expense amount
5. **Submit the Claim Form.** Retain original copies for your records and mail both pages of the form and required documentation to:

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

If you request a reissue for a reimbursement to you for any reason, there is a $25 stop payment fee.

Questions? Call (888) 831-4753

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_2958-02-1020_M Accepted 10272020

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All fields are required. To verify or update your mailing address or email address, contact Network Health.

Network Health Member Information

First Name

Last Name

Phone Number

Network Health Member ID

Expense Information (Submit additional forms if you have more than two expenses. Enter one receipt that shows the purchase of multiple items as one expense.)

Benefit Type (from instructions page)

Service/Purchase Start Date (mm-dd-yyyy)

$

Provider or Retailer Name

Claim Amount

Service/Purchase End Date (mm-dd-yyyy)

Benefit Type (from instructions page)

Service/Purchase Start Date (mm-dd-yyyy)

$

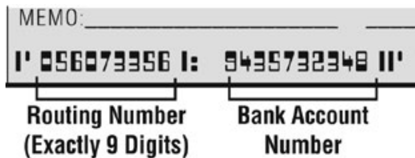
Provider or Retailer Name

Claim Amount

Service/Purchase End Date (mm-dd-yyyy)

Direct Deposit Information

Financial Institution



Account Type: Checking Savings

Routing Number (exactly 9 digits from check)

Account Number (from check)

In most cases, the routing number precedes the account number. If in doubt, contact your financial institution.

I do not have direct deposit. Mail me a check, which takes longer than direct deposit. Checks are mailed within 8 business days and delivered within regular postal mailing times.

Authorization

I certify that my statements on this form are complete and true. I understand that it is my responsibility to submit only eligible expenses defined by my plan and I am claiming reimbursement only for eligible expenses incurred during the applicable plan year. I certify that these expenses have not been, nor will be, reimbursed by any other benefit plan. I understand Employee Benefits Corporation, a partner of Network Health, may need "protected health information" regarding coverage or benefits under the plan. By submitting this form, I hereby acknowledge that Employee Benefits Corporation will obtain and use such information and disclose it to an insurer or other provider of services related to the plan, but only for the purposes of the plan and only for as long as Employee Benefits Corporation is providing services regarding the plan. Any information disclosed pursuant to this form will not be subject to re-disclosure by the recipient, except for purposes of the plan.

By including direct deposit information, I authorize Employee Benefits Corporation to send reimbursements (and appropriate adjusting entries) electronically or by any other commercially accepted method to my designated account at the financial institution named above. I agree not to hold Employee Benefits Corporation 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. It is my responsibility to notify Employee Benefits Corporation immediately of any changes in my financial institution (i.e., change of account number or closure of account). 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.

By submitting this form, I agree to receive all communications electronically. If I prefer not to receive communications electronically, I've checked the box that indicates my preference.

I prefer to receive Pick Your Perks communications by mail.

By submitting this form I certify the above.

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