network health | Supported by Employee Benefits Corporation

2025 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 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 submitted within the 120-day deadline.

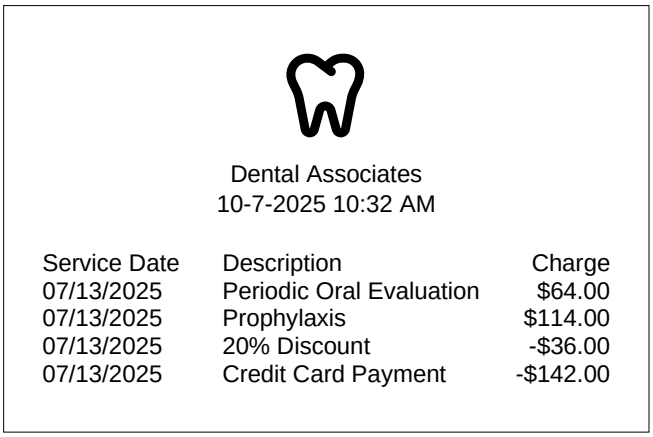
View more details about eligible expenses in your Evidence of Coverage at **networkhealth.com/medicare/plan-materials** or in your Network Health member portal. Everyday items such as over-the-counter allergy medicine, cold and flu relief, dental floss and more are eligible for reimbursement.

Submit Claim Online:
Log in at login.networkhealth.com and click the *Pick Your Perks* quick access button. Complete the form, upload documentation and submit.

Mail Claim Form To:
Employee Benefits Corporation
PO Box 44347
Madison, WI 53744-4347

Required Documentation
The table below shows the documentation required for each benefit type. Copies of your documentation are required, or your claim cannot be processed. 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
10-7-2025 10:32 AM

Service Date	Description	Charge
07/13/2025	Periodic Oral Evaluation	$64.00
07/13/2025	Prophylaxis	$114.00
07/13/2025	20% Discount	-$36.00
07/13/2025	Credit Card Payment	-$142.00

Itemized Receipt Sample

Benefit Type	Required Documentation
Acupuncture	Itemized invoice or receipt
Dental	Itemized invoice or receipt
Home delivered meals from Mom's Meals	Itemized invoice or receipt from Mom's Meals -AND- proof of qualifying stay -OR- doctor's note attesting to qualifying condition
Massage	Invoice or 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 invoice or receipt
Nutritional/dietary counseling	Itemized invoice or receipt
Personal training (up to 4 visits annually with a $225 annual limit)	Itemized invoice or receipt
Vision hardware	Itemized invoice or 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 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 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
		$	☐
		$	☐
		$	☐
		$	☐
		$	☐

Reimbursement – Please check one.

☐ Use the direct deposit information already on file.
☐ Add or update my direct deposit using the information recorded immediately below.

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

☐ Mail me a check, which may take 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.