network health | Supported by Employee Benefits Corporation

2025 ACA Dental Claim Form

ACA Dental Claim Form

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.** A separate claim form is required for each individual Network Health Member, including spouses and dependents. Your service does not need to be paid in full to submit your claim for reimbursement. You may request reimbursement as services are rendered to ensure claims are submitted within the 120-day deadline.

View more details about eligible expenses in your Individual Health Maintenance Organization (HMO) Medical Policy by visiting your member portal at **login.networkhealth.com**.

Submit Claim Online:
Log in at login.networkhealth.com and click *Dental Benefits* from the My Benefits drop down menu. Complete the form, upload documentation and submit.

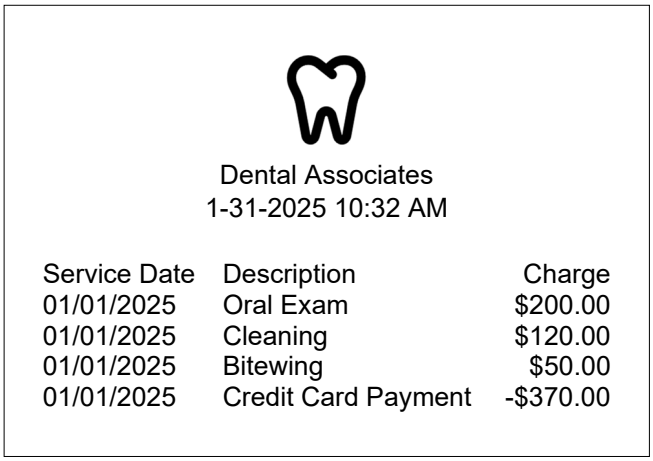
Mail Claim Form To:
Employee Benefits Corporation
PO Box 44347
Madison, WI 53744-4347

Required Documentation
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.

- Provider name
- Date of service
- Service received
- Cost of the service/billed charges

Eligible Benefits
Only the benefits listed below are eligible for reimbursement under your plan. No other dental related expenses are eligible.

- Oral Exams (up to 2 annually)
- Cleanings (up to 2 annually)
- Bitewing (1 annually)



Dental Associates
1-31-2025 10:32 AM

Service Date	Description	Charge
01/01/2025	Oral Exam	$200.00
01/01/2025	Cleaning	$120.00
01/01/2025	Bitewing	$50.00
01/01/2025	Credit Card Payment	-$370.00

Itemized Receipt Sample

Note: A bitewing x-ray shows the upper and lower teeth in one area of your mouth. Panoramic, Intraoral and Tomographic imaging is not considered an eligible benefit.

Questions? Call us at 1-888-831-6108

network health | Supported by Employee Benefits Corporation

2025 ACA Dental Claim Form

Network Health Member Information *(include details for the member receiving services)*

Last Name _____ First Name _____

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

Expense Information

Complete one line for each expense type below. Check the corresponding box to identify if the expense is an oral exam, cleaning, or bitewing x-ray. Do not list multiple expense types on a single line. Claims and documentation must be submitted within **120 days** of service. **Mail claims to Employee Benefits Corporation at PO Box 44347, Madison, WI 53744-4347.**

Date of Service	Dental Provider Name	Billed Amount	Check One
		$	☐ Oral Exam ☐ Cleaning ☐ Bitewing
		$	☐ Oral Exam ☐ Cleaning ☐ Bitewing
		$	☐ Oral Exam ☐ Cleaning ☐ Bitewing

Reimbursement – Please check one.

☐ Use the direct deposit information already on file. Direct deposit is the fastest and most secure way to receive reimbursement.

☐ 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**. Checks are payable to the covered member receiving services, regardless of age.

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. 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 and 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.

##62T01604####################