



Instructions: Please complete and return the enclosed forms and copies of your itemized bills to CHM (even if a discount is pending) to begin the sharing process for your medical bills in accordance with the CHM Guidelines. (Please limit to one incident per form.)



1. Patient and illness information

Member number: _____

Primary member name: _____

Phone number: _____

Email: _____

I'd like any available credits* applied to my Personal Responsibility: Yes No

**Your available credits could include Bring-a-Friend credits or membership monthly contributions paid in advance.*

Patient name: _____

Patient date of birth: ____/____/____ Age: ____

Illness and/or symptom(s): _____

Date symptoms started: ____/____/____



Pre-existing conditions

If applicable, I've had the following:

Signs and/or symptoms (and the date(s) they occurred):

Treatment and/or testing (and the date(s) they occurred):



2. Letter of explanation

Please add additional pages if necessary.



3. Consent

I understand that CHM members participate out of a desire to share one another's burdens, and it would be an abuse of their trust if I use the money I receive for a sharing request for some purpose other than payment of that medical bill. If I have prepaid or made payments, I will consider funds received from CHM as reimbursement. I understand that failure to provide accurate information or failure to use the money for the submitted bills will be a violation of Christian Healthcare Ministries Guidelines and a fraud upon the ministry (CHMinistries.org/chm-guidelines) [Section II(E)(10)(e)]. By signing below, I attest that the participating adult members included in my membership are Christians who attend worship regularly as health permits, actively follow the teachings of the New Testament in its entirety, and live a Christian lifestyle consistent with CHM's Statements of Beliefs (expressed in CHM's Guidelines). I also attest that all information provided herein is true to the best of my knowledge.

Signed: _____ Date: ____/____/____

Must be signed by patient if patient is 18 years of age or older.

Instructions: Please complete this section to reflect each bill included in your sharing request. *Completed forms and itemized bills must be received by CHM within six months of the date of service. Missing forms or unitemized bills may cause delay in sharing.*

Member number: _____ Patient name: _____

Is this an add-on? Yes No If yes, which incident/illness? _____

Primary payment options and financial assistance

CHM is secondary to all other payment options; we request that you use any financial assistance resources when available.

Primary insurance Other: _____

Start date: ____ / ____ / ____ End date: ____ / ____ / ____

Financial assistance: Pending Approved Denied

Provider: _____

	DATE OF SERVICE	BILLING PROVIDER	ORIGINAL CHARGES	DISCOUNTS	PAYMENTS
1			\$	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> Included in charge <input type="checkbox"/> None available	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> On a payment plan <input type="checkbox"/> None made
2			\$	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> Included in charge <input type="checkbox"/> None available	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> On a payment plan <input type="checkbox"/> None made
3			\$	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> Included in charge <input type="checkbox"/> None available	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> On a payment plan <input type="checkbox"/> None made
4			\$	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> Included in charge <input type="checkbox"/> None available	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> On a payment plan <input type="checkbox"/> None made
5			\$	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> Included in charge <input type="checkbox"/> None available	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> On a payment plan <input type="checkbox"/> None made
6			\$	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> Included in charge <input type="checkbox"/> None available	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> On a payment plan <input type="checkbox"/> None made
7			\$	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> Included in charge <input type="checkbox"/> None available	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> On a payment plan <input type="checkbox"/> None made
8			\$	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> Included in charge <input type="checkbox"/> None available	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Shown on bill <input type="checkbox"/> On a payment plan <input type="checkbox"/> None made



1. Patient and illness information

Patient Name: _____ Member Number: _____

Patient date of birth: ____ / ____ / ____ Last four of SSN: _____

Address: _____ Phone Number: _____



2. Consent to release

I understand that Christian Healthcare Ministries is a non-profit medical cost sharing organization that coordinates assistance for its members' eligible medical bills. **Christian Healthcare Ministries is not an insurance company, nor is it offered through an insurance company.**

I hereby authorize any medical practitioner, hospital, health facility, insurance company, or any other person or entity that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein to disclose my protected health information to Christian Healthcare Ministries for the purpose of facilitating the eligibility and sharing process by Christian Healthcare Ministries and also negotiating medical bills on the undersigned's or dependent's behalf.

I further authorize Christian Healthcare Ministries to discuss any health information related to my records described in this authorization with healthcare providers, healthcare facilities, health plans, or any other agency involved in my healthcare or payment for healthcare.

Please initial one of the options below:

_____ I consent that all medical records be disclosed (complete health record plus records regarding all bills, billing codes, diagnosis codes, and other billing information). This includes information on communicable diseases (including HIV/AIDS), alcohol/drug abuse treatment, and mental health records and treatment.

_____ I do not consent that my medical records be disclosed. *Important: CHM and your healthcare providers must have your consent to legally discuss discounts on your behalf.*



3. Important notes

By signing below, I understand that:

- this authorization shall expire upon the expiration of one (1) year, or until revoked by me in writing, whichever comes first.
- treatment and eligibility for sharing is not conditioned on my failure to execute this authorization.
- this authorization is voluntary and that I may revoke the authorization in writing addressed to 127 Hazelwood Ave, Barberton, OH 44203.
- this authorization may not be revoked where Christian Healthcare Ministries has already reasonably acted in reliance upon this authorization.
- the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law.
- a copy of this form, including a facsimile, may be used in place of the original.

*Signature of patient or authorized representative

Print name of patient

**Authorized representative's relationship to patient

Print name of authorized representative

**Must be signed by patient if patient is 18 years of age or older*

***Authorized representative's signature is required if patient is under the age of 18 or is incapable of signing for themselves.*

If patient is incapable of signing for themselves, please include power of attorney documents.

Today's date: ____ / ____ / ____ **Important: This form must be returned to CHM signed and dated or it will be invalid.**



1. What is the Prayer Page?

The Prayer Page is a Spirit-led option that enables the sharing of eligible medical bills for maintained pre-existing conditions. Prayer Page is funded by voluntary donations to provide additional support to members with maintained conditions. Names, addresses, and basic information about members' pre-existing conditions are listed on the Prayer Page.

TO QUALIFY FOR THE PRAYER PAGE:

1. Medical bills must be incurred as eligible treatment for a maintained, pre-existing condition as defined in the CHM Guidelines located here: CHMinistries.org/chm-guidelines.
2. Medical bills must be incurred after joining CHM. Bills incurred prior to membership are not eligible.



2. Active vs maintained pre-existing conditions

MAINTAINED PRE-EXISTING

A pre-existing illness is considered maintained if you have gone at least 90 days without testing or treatment; your medical provider states that no further testing or treatment is needed; and your medical records show that you are cured or on a maintenance treatment regimen.

ACTIVE PRE-EXISTING

A condition is considered active and medical bills cannot be shared if you have experienced any signs or symptoms either before or at the time of joining CHM (regardless of whether or not you've received a diagnosis) **and** your condition actively needs treatment other than maintenance (routine) medications.



3. Member information and consent

Member number: _____ Patient name: _____

Illness and/or symptom(s) to be listed on the Prayer Page: _____

Signed: _____ Date: ____/____/____

By signing, if my eligible medical bills qualify, I agree to have them listed on the Prayer Page.



Editor's note: To see if your medical bills are eligible for Prayer Page sharing, please scan the QR code to review the CHM Guidelines (CHMinistries.org/chm-guidelines).



Instructions: Please fill out the following sections to acknowledge that you have read and understand CHM's maternity Guidelines ([CHMinistries.org/chm-guidelines](https://www.chministries.org/chm-guidelines)). Please review our maternity page ([CHMinistries.org/blog/maternity](https://www.chministries.org/blog/maternity)) for more pregnancy-related resources.



1. Patient information

Member number: _____

Patient name: _____



2. Qualifying for sharing

To qualify for maternity sharing, CHM members must meet the following criteria:

- The member must be married at the time of conception.
- The member must have participated at CHM Gold at least 300 days prior to the expected due date.

The entire maternity incident is ineligible if the member does not meet the preceding qualifications.

Was the pregnancy a result of IVF (in vitro fertilization) or embryo implant, transfer, or adoption? Yes No
Pregnancies resulting from these treatments/procedures are not eligible (see CHM Guidelines for more information).

Expected due date: ____ / ____ / ____ or baby's date of birth: ____ / ____ / ____

I'd like any available credits* applied to my Personal Responsibility: Yes No

**Your available credits could include Bring-a-Friend credits or membership monthly contributions paid in advance.*



3. Maternity information

Do you plan to deliver at a hospital, birthing center, or home?

Hospital Birthing center Home

Have you chosen a hospital or birthing center yet?

Yes No

CHM's maternity nurse navigator can connect you with a high-quality healthcare provider in your area (see [CHMinistries.org/blog/maternity](https://www.chministries.org/blog/maternity) for more information).

Do you have primary forms of payment available?

Primary insurance Medicaid Financial assistance

Other: _____

Start date: ____ / ____ / ____

End date: ____ / ____ / ____

CHM is secondary to all other payment options; we request that you use any financial assistance resources when available.



4. Consent

I understand that CHM members participate out of a desire to share one another's burdens, and it would be an abuse of their trust if I use the money I receive for shared medical bills for some purpose other than payment of those medical bills. If I have prepaid or made payments, I will consider funds received from CHM as reimbursement. I understand that failure to provide accurate information or failure to use the money for the submitted bills will be a violation of Christian Healthcare Ministries' Guidelines ([CHMinistries.org/chm-guidelines](https://www.chministries.org/chm-guidelines)).

By signing below, I attest that the participating adult members included in my membership are Christians living by New Testament principles, who embrace the CHM Statements of Beliefs, attend group worship regularly (health permitting), follow scriptural teaching with regard to alcohol, and abstain from use of any form of tobacco, nicotine, or illegal drugs. I also attest that all information provided herein is true to the best of my knowledge.

Member name: _____

Member signature: _____ Date: ____ / ____ / ____

Must be signed by patient if patient is 18 years of age or older.