CHM Christian Healthcare Ministries

Sharing Request Form

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 Refer-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

I've had the following (if applicable):

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

_____

_____

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

_____

_____

2. Payment sources

Do you have insurance, Medicare, Medicaid, or any other forms of payment? ☐ Yes ☐ No

Members should submit bills to the appropriate insurance, Medicare, Worker's Compensation, fraternal benefits, or any other resource available to pay all or part of the bills.

3. Financial assistance

I have applied or am in the process of applying for financial assistance. ☐ Yes ☐ No

4. Accidents (if applicable)

Accident occured at: ☐ Home ☐ Other (specify): _____

If the accident occurred on property other than your own, all bills must be submitted to the responsible party's insurer.

5. Letter of explanation

_____

_____

_____

_____

_____

_____

_____

Please add additional pages if necessary.

6. 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]. 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.

CHM Christian Healthcare Ministries

Medical Bill Worksheet

Instructions: Please complete this worksheet 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 non-itemized bills may cause delay in sharing.*

Member number: _____ Patient name: _____

Is this a new bill for a previous submission? ☐ No ☐ Yes (please specify): _____

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.

☐ Yes, I have primary insurance ☐ Other: _____

Start date: _____ / _____ / _____ End date: _____ / _____ / _____

Financial assistance: ☐ Pending ☐ Approved ☐ Denied

Provider: _____

	DATE OF SERVICE	BILLING PROVIDER	ORIGINAL CHARGES	DISCOUNTS	PAYMENTS
1			$	☐ $_____ ☐ Shown on bill ☐ Included in charge ☐ None available	☐ $_____ ☐ Shown on bill ☐ On a payment plan ☐ None made
2			$	☐ $_____ ☐ Shown on bill ☐ Included in charge ☐ None available	☐ $_____ ☐ Shown on bill ☐ On a payment plan ☐ None made
3			$	☐ $_____ ☐ Shown on bill ☐ Included in charge ☐ None available	☐ $_____ ☐ Shown on bill ☐ On a payment plan ☐ None made
4			$	☐ $_____ ☐ Shown on bill ☐ Included in charge ☐ None available	☐ $_____ ☐ Shown on bill ☐ On a payment plan ☐ None made
5			$	☐ $_____ ☐ Shown on bill ☐ Included in charge ☐ None available	☐ $_____ ☐ Shown on bill ☐ On a payment plan ☐ None made
6			$	☐ $_____ ☐ Shown on bill ☐ Included in charge ☐ None available	☐ $_____ ☐ Shown on bill ☐ On a payment plan ☐ None made
7			$	☐ $_____ ☐ Shown on bill ☐ Included in charge ☐ None available	☐ $_____ ☐ Shown on bill ☐ On a payment plan ☐ None made
8			$	☐ $_____ ☐ Shown on bill ☐ Included in charge ☐ None available	☐ $_____ ☐ Shown on bill ☐ On a payment plan ☐ None made

1. Patient and illness information

Patient Name: _____ Member Number: _____

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

Address: _____ Phone Number: _____

2. Patient and illness information

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.
- signing this authorization is not a requirement to receive treatment or medical services. However, I understand that if CHM is unable to communicate with my provider(s) about my treatment or services, CHM may not be able to verify the eligibility of those treatments or services for sharing.
- 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 CHM Give?

CHM Give is a Spirit-led option that enables the sharing of eligible medical bills for maintained pre-existing conditions. CHM Give is funded by voluntary donations to provide additional support to members with maintained conditions. Basic information about members and their pre-existing conditions may be listed on the CHM Give page (***portal.CHMinistries.org/give***).

TO QUALIFY FOR CHM GIVE:

1. Medical bills must be incurred as eligible treatment for a maintained, pre-existing condition as defined in the CHM Guidelines located here: ***portal.CHMinistries.org***.
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 your medical records show that you are on a maintenance treatment regimen, your medical provider states that no further testing or treatment is needed, ***and*** at least 90 days have passed without undergoing testing or treatment.

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 ***and/or*** your condition actively needs testing or treatment other than maintenance (routine) medications, regardless of whether or not you've received a diagnosis

3. Member information and consent

Member number: _____ Patient name: _____

Illness and/or symptom(s) to be listed on CHM Give: _____

_____

Date: _____ /_____ /_____ Signed: _____

By signing, if my medical bills are eligible for sharing, I agree to have them listed on the CHM Give page.

Editor's note: To see if your medical bills are eligible for sharing through CHM Give, please scan the QR code to review the CHM Guidelines located on your Member Portal (***portal.CHMinistries.org***).

CHM Christian Healthcare Ministries

Maternity Verification Form

Instructions: Please complete the following sections to acknowledge that you have read and understand CHM's maternity Guidelines, which can be found on your Member Portal (***portal.CHMinistries.org***).

1. Patient information

Member number: _____ Spouse name: _____

Patient name: _____ Spouse DOB: _____ / _____ / _____

Would you like to add your spouse as an authorized user on your membership? ☐ Yes ☐ No

2. Qualifying for sharing

The entire maternity incident is ineligible if the member does not meet the following criteria:

- The member must be married at the time of conception.
- The member must have a membership start date of at least 300 days prior to the expected due date.

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 Refer-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/maternity** for more information).*

Do you have primary forms of payment available?

☐ Primary insurance ☐ Medicaid ☐ Financial assistance

☐ None ☐ 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 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].

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.

Member name: _____

Member signature: _____ Date: _____ / _____ / _____

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

Congratulations! Please review and initial the following sections to acknowledge that you have read and understand CHM's maternity Guidelines. Be sure to review the maternity Guidelines located on your Member Portal (***portal.CHMinistries.org***) and maternity page (***CHMinistries.org/maternity***) for eligibility and processing-related questions.

1. Adding your new baby

Any medical bills your baby incurs within the first 30 days after birth will be processed as part of the mother's maternity incident. Medical bills incurred after the first 30 days must be shared under the child unit. **Exception:** Any services related to a congenital birth defect must be processed under the baby's unit from date of birth (see the Guidelines under Resources at ***portal.CHMinistries.org*** for more information).

Newborn babies must be added to your CHM membership for continued sharing eligibility. ***Contact the Maternity Care Team at 800-791-6225 within the first 30 days after delivery to add your baby to your membership.*** Please indicate whether the baby will participate in the optional CHM Plus program detailed in the CHM Guidelines.

If the new baby is the first child on your membership, the unit number will increase by one and the member monthly contribution also will increase. The monthly contribution amount won't increase if your membership already includes a child unit.

I UNDERSTAND *(initial here):* _____

2. Existing child unit

We strongly encourage you to move all existing children to the CHM Gold program prior to your expected birth month.

Once an illness begins with signs, symptoms, testing, or treatment at a lower program for an existing child, it will remain at that lower program for the lifetime of the membership. This applies regardless of whether medical bills have been previously submitted for sharing. Medical records may be requested.

New illnesses will be eligible for CHM Gold after the CHM Gold start date.

If your existing child unit is participating on CHM Bronze or CHM Silver and you wish to upgrade, please contact us at 800-795-6225 or visit your Member Portal (***portal.CHMinistries.org***) to request a program change.

Please allow 30 days for any requested changes to take effect.

I UNDERSTAND *(initial here):* _____

3. Member information

Member name: _____ Member # _____

Signed: _____ Date: _____ / _____ / _____