Christian Health Aid
...sharing makes a difference...

PO Box 336 – Montezuma KS 67867

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Traditional Plan

Self-pay Medical Bill Request for Sharing

Eligible medical bills are shared by members who contribute to help bear the burden of other members' health care costs.

Patient name: _____ Membership number: _____

Contact Information: Name of responsible party: _____

Home phone number: _____ Cell Phone: _____

Email address: _____

Give the doctor's diagnosis for the bills you are submitting _____

Explain the reason for your visit to the hospital or clinic:

_____
_____
_____
_____
_____
_____
_____

For Accidents: What is the date of the accident? _____
Is there any liability, worker's compensation, or other insurance with benefits for the bills relating to this accident?
Yes ☐ No ☐ If yes please indicate the type of benefit and name of the provider:

_____
_____

For Maternity: What is the expected delivery date? _____

Record all bills submitted on page 2 of this form.

CHA is secondary to all other sources of reimbursement for a member's medical bills, including any health insurance, liability insurance, worker's compensation, or other aid programs in which the member participates, with the exception of Medicaid. Medical bills must be submitted to these sources first and all resources exhausted before bills will be considered for sharing.

Signed: _____ Date _____ Continued on next page

TRADITIONAL PLAN

Self-pay Medical Bill Request for Sharing Spreadsheet

Patient Name: _____ Date of Birth: _____ Member #: _____

Record on this page the requested information for each itemized bill being submitted.

Dates of service FROM	TO	Name of Medical Service Provider	Billed Amount	Any Discount already received	Other Reimbursement	Amount that is your responsibility
		TOTALS	0	0	0	0

Please include each of the following when submitting your bill for processing:

1. The signed and completed Request for Sharing.

2 An itemized bill for each item listed above which includes diagnosis and procedure codes. Standardized billing forms such as UB-04 or CMS-1500 are acceptable documentation. These billing forms provide all of the information we need to process your bill correctly.

3. Signed and completed CHA HIPAA Authorization Form

CHRISTIAN HEALTH AID HIPAA AUTHORIZATION FORM

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize physicians, hospitals, and other medical personnel to disclose protected health information about me to Christian Health Aid/Century Health Alliance for the purpose of determining eligibility and negotiating payment.

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

1. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
2. I may revoke this authorization by notifying the provider/hospital/medical personnel in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
3. This authorization will expire in one (1) year unless revoked in writing.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

_____	_____	_____
Signature of Responsible Party	**Date of Responsible Party's Signature**	**Description of Authority to Act for the Individual (e.g., parent/guardian)**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only		
_____	_____	_____
Received	**Processed By**	**Log #**