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## Diabetic Supplies Benefit Enrollment/Renewal Form

CHA has a program to share diabetic supply expenses based on the amount of expenses incurred according to the terms outlined below. If you qualify for this benefit and wish to be enrolled in the program, please complete and submit this form.

- Once a member is enrolled in the program, we will process shared amounts every month without requiring additional monthly submission of bills.
- You must provide receipts of one month's expenditures to annually renew your diabetic supplies benefits.
- CHA members will share up to \$400.00 per month for diabetic expenses for insulin dependent (Type 1) diabetic members.
- CHA members will share up to \$200.00 per month for diabetic expenses for non-insulin dependent (Type 2) diabetic members.
- Please fill out the section below using a separate line for each product listed on the receipt. Please indicate the product, place of purchase, cost, number of days the supply lasts, and the cost per month. Please include receipts for at least one month's diabetic supplies. We cannot process your enrollment without receipts. Do not hesitate to contact us at one of the options listed above if you have questions regarding this enrollment.

Product name such as "Test Strips" or "Humalog"

Place where the product was purchased.

(Please submit only one receipt per line item.)

Total dollar amount for the product. Sales tax and shipping may be included.

Number of days the quantity purchased lasts.  
(For example, if you buy 200 test strips and use 3 per day, this will last 66 days.)  
88

Column 3, divided by Column 4, multiplied by 30 (days in a month)

COLUMN 1 PRODUCT NAME	COLUMN 2 PLACE OF PURCHASE	COLUMN 3 PURCHASE PRICE AS SHOWN ON RECEIPT	COLUMN 4 NUMBER OF DAYS THE PRODUCT LASTS	COLUMN 5 COST PER MONTH

TOTAL COST PER MONTH: \_\_\_\_\_

Qualified Member: \_\_\_\_\_

Membership number: \_\_\_\_\_

Please indicate Diabetic Type: ☐ Insulin dependent

☐ Non-insulin dependent

I have attached receipts and certify that I am (or my dependent designated above is) a diabetic of the type I have indicated.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_