



**All Programs**  
**Self-pay Medical Bill Request for Sharing Spreadsheet**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member #: \_\_\_\_\_

List the requested information for each itemized bill you are submitting.

	Dates of service		Name of Medical Provider (Clinic / Hospital)	Original Billed Amount	Discount/Adjustment Amount	Amount that is your responsibility	Have you paid this bill? Yes / No / Partial \$
	FROM	TO					
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
TOTALS:							

**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 procedure codes/descriptions. Standardized billing forms such as UB-04 or CMS-1500 are acceptable documentation. These billing forms provide the information we need to process your bill correctly.