Christian Health Aid
PO Box 336
Montezuma, KS 67867

Phone: (620) 846-2286
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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 you may complete and sign this form and return it to the above address.

- Once a member is enrolled in the program, we will process shared amounts every month without requiring additional monthly submission of bills. Shared amounts will be processed monthly even though supplies may be purchased several months at a time.
- Once a year you will be required to renew your diabetic supplies benefits by providing receipts of one month's expenditures.
- CHA members will share up to $300.00 per month for diabetic expenses for insulin dependent (Type 1) diabetic members.
- CHA members will share up to $150.00 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 call if you have questions regarding this enrollment.

Product name such as "Test Strips" or "Humalog" (A receipt for each item must be provided.)

Name of place where the product was purchased. (Please submit only one receipt per line item.)

Enter the total dollar amount for the product shown on the receipt. 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.)

Start with Column 3
Divide by Column 4
Multiply by 31 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: _____