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

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Montezuma KS 67867

Phone: 620-846-2286 Fax: 888-879-0324
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Scan for online form

Diamond Care Sharing & Emerald Care Sharing
Self-pay Medical Bill Request for Sharing

- For members on the Diamond Care Sharing submit bills for incidents that exceed $1000.
- For members on the Emerald Care Sharing submit bills for incidents that exceed $5000.
- An incident is testing and/or treatment for a medical condition, injury, or illness.
- Eligible medical bills are shared by members who contribute to help bear the burden of other members' health care costs.
- Members remain responsible to pay their own medical bills. There is no guarantee that any bill submitted for sharing will receive any payment from the ministry.

Patient name: _____ Membership number: _____

Contact Information: Name of responsible party: _____

Home phone number: _____ Cell Phone: _____

Email address: _____

In the spaces below enter the doctor's diagnosis and explain the incident for which you are requesting assistance from the member sharing fund.

Doctor's diagnosis _____ ***If the diagnosis is not on the detailed bill you might need to ask for the information from the doctor's notes.***

Details of incident:

_____
_____
_____
_____
_____
_____

What date did the symptoms or treatment for this condition begin? _____

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? _____ *This information is recorded in clinic visit notes and OB ultrasound reports.*

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.

I understand that self-pay medical bills eligible for sharing as incidents are reviewed and negotiated to establish fair pricing. For this reason it is important that members do not pay their bills on the date of service unless they are confident that the entire incident will be their responsibility to pay.

Signed: _____ Date _____ Continued on next page

DIAMOND CARE SHARING & EMERALD CARE SHARING

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. All of the bills should pertain to a single incident.

	Dates of service FROM	TO	Name of Medical Service Provider	Original Billed Amount	Any Discount already received	Amount that is your responsibility	Have you paid this bill? Yes / No
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 diagnosis and procedure codes. 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.**

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	**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 reductions in bills and for potential bill sharing payments.

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 #**