CHM Christian Healthcare Ministries

Eligibility Review Request

Instructions: Please complete and return a copy of this form, the attached Medical Information Release form, and medical records to: Christian Healthcare Ministries, 127 Hazelwood Ave., Barberton, OH 44203. Alternatively, you can email the forms to ***info@CHMinistries.org*.**

Please note, email is not a secure method for sending medical forms or information.

1. Personal information

Select description: ☐ Groups member ☐ Prospective member ☐ General member

Primary contact name: First: _____ Middle: _____ Last: _____

Email: _____ Phone: _____

Patient name: First: _____ Middle: _____ Last: _____

Birthdate: _____ / _____ / _____ Age: _____

Patient address: _____

2. Membership information and program

Member number (if applicable): _____

Group name (if applicable): _____ Group number (if applicable): _____

Program: ☐ CHM Gold ☐ CHM Silver ☐ CHM Bronze ☐ CHM SeniorShare™ CHM Plus: ☐ Yes ☐ No

(Indicate the program the patient participates on or intends to join.)

3. Medical history

Please list the condition(s) for which the patient has a personal history. Note the day the symptoms began.

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

4. Current problem

For what condition(s) are you requesting a sharing eligibility review? _____

When did the signs, symptoms, testing, and/or treatment for this condition begin? _____

4. Current problem (continued)

Details of illness in order of occurrence: _____

_____

_____

Please list any treatments or diagnoses the patient already received for the current condition and the date received *(Please include doctor visits, emergency room visits, hospitalizations, lab work, scans and imaging, diagnostic testing, and medications.)*:

_____

_____

Do medical records indicate that the condition is cured, in remission, or maintained with routine medication (circle one)?

If so, what date did this occur ☐ Yes, on _____ / _____ / _____ ☐ No

5. Medical records

Please list any providers the patient has seen regarding the condition(s). We may request medical records from one or more of these providers during the medical review process.

Provider: _____ Service date: _____ / _____ / _____

Phone: _____ Fax _____

Provider: _____ Service date: _____ / _____ / _____

Phone: _____ Fax _____

Provider: _____ Service date: _____ / _____ / _____

Phone: _____ Fax _____

6. Consent

By signing below, I acknowledge that:

- The information I receive from Christian Healthcare Ministries is a good faith opinion and is reliant on the accuracy and completeness of the information I have provided.
- All medical expenses are subject to a final review upon the completion and submission of CHM's required Sharing Request Packet and itemized bills.
- All medical expenses will be shared or determined ineligible in accordance with the CHM Guidelines (***info.CHMinistries.org/guidelines-sign-up***).

Signed: _____ Date: _____ / _____ / _____

Printed name: _____

Must be signed by patient if patient is 18 years of age or older.

Thank you for completing and returning this form to the address indicated on the front. Please allow at least two weeks from the time CHM receives your documentation for your request to be fully processed. In some cases, CHM may require additional medical documentation and/or additional processing time to complete the review.

1. Patient and illness information

Patient Name: _____ Member Number: _____

Patient date of birth: _____ /_____ /_____ Last four of SSN: _____

Address: _____ Phone Number: _____

2. Consent to release

I understand that Christian Healthcare Ministries is a non-profit medical cost sharing organization that coordinates assistance for its members' eligible medical bills. **Christian Healthcare Ministries is not an insurance company, nor is it offered through an insurance company.**

I hereby authorize any medical practitioner, hospital, health facility, insurance company, or any other person or entity that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein to disclose my protected health information to Christian Healthcare Ministries for the purpose of facilitating the eligibility and sharing process by Christian Healthcare Ministries and also negotiating medical bills on the undersigned's or dependent's behalf.

I further authorize Christian Healthcare Ministries to discuss any health information related to my records described in this authorization with healthcare providers, healthcare facilities, health plans, or any other agency involved in my healthcare or payment for healthcare.

Please initial one of the options below:

_____ I consent that all medical records be disclosed (complete health record plus records regarding all bills, billing codes, diagnosis codes, and other billing information). This includes information on communicable diseases (including HIV/AIDS), alcohol/drug abuse treatment, and mental health records and treatment.

_____ I *do not* consent that my medical records be disclosed. *Important: CHM and your healthcare providers must have your consent to legally discuss discounts on your behalf.*

3. Important notes

By signing below, I understand that:

- this authorization shall expire upon the expiration of one (1) year, or until revoked by me in writing, whichever comes first.
- signing this authorization is not a requirement to receive treatment or medical services. However, I understand that if CHM is unable to communicate with my provider(s) about my treatment or services, CHM may not be able to verify the eligibility of those treatments or services for sharing.
- this authorization is voluntary and that I may revoke the authorization in writing addressed to 127 Hazelwood Ave, Barberton, OH 44203.
- this authorization may not be revoked where Christian Healthcare Ministries has already reasonably acted in reliance upon this authorization.
- the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law.
- a copy of this form, including a facsimile, may be used in place of the original.

_____ _____

*Signature of patient or authorized representative Print name of patient

_____ _____

**Authorized representative's relationship to patient Print name of authorized representative

**Must be signed by patient if patient is 18 years of age or older Authorized representative's signature is required if patient is under the age of 18 or is incapable of signing for themselves. If patient is incapable of signing for themselves, please include power of attorney documents.*

Today's date: _____ /_____ /_____ ***Important: This form must be returned to CHM signed and dated or it will be invalid.***