# Christian Healthcare Ministries

*The biblical solution to healthcare costs*

The Rev. Dr. Howard S. Russell, *President & CEO*
127 Hazelwood Avenue • Barberton, Ohio 44203
330.848.1511 *phone* • 800.791.6225 *toll free* • 330.848.4322 *fax*
www.chministries.org

Dear Friend:

If you have been ill, I am sorry to hear of your medical need. I want you to know that all of us here at the Christian Healthcare Ministries office are praying for your recovery. We will especially lift you up during our chapel services each Thursday morning at 9:30 a.m. Eastern time.

If you are reading this letter because you're expecting a child, congratulations! We want to help ease your mind during this exciting—and potentially stressful—time.

Regardless of the circumstances, before the onset of time God knew this day would cross your path, and even then He began to prepare you and those around you. He knew just what it would take to see you through this time. He will not fail you now.

Sometimes anxiety about a physical condition is multiplied by the concern for the financial burden incurred. However, thousands of Christians are ready to help you. While your needs are being prepared for sharing, please accept the following advice. It will make your next few months much more comfortable.

When you have a medical need, don't hesitate to tell medical providers that you are "self pay." Also, tell them that you are part of a ministry of Christians who share each other's medical bills. **CHM members have shared more than $1 billion of other Christians' needs.** They will now help shoulder your burden as well.

Please don't hesitate to ask for reductions (discounts) on your bills. Health care providers regularly give reductions to insurance companies and will not be offended if you ask. Additionally, obtaining reductions will save money that can be used to help other CHM members. Providers often will give you a reduction much greater than what they would give CHM on your behalf.

Within this packet, you will find more detailed information about medical and maternity needs processing. If you have questions, please don't hesitate to call or write us so we can help you.

God bless you.

Howard S. Russell

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# What to do when you need medical care

## In emergency situations:

1) ***Immediately seek medical care.*** Call 9-1-1 if the situation is life threatening. If you are a Gold member and your condition is less serious but requires immediate care, consider if an urgent care center will meet your needs (emergency rooms are usually more expensive than urgent care centers).
2) ***Seek financial assistance when you are well.*** Getting well is your first priority. When your condition is stable, you, a friend or a family member responsible for your care can follow steps under “General information” below.

## In non-emergency situations:

1) ***Consider “shopping around” for health care providers in your area.*** You’ll find that some health care providers are more willing than others to reduce their charges for self-pay patients. Although you may go to any hospital or doctor office for treatment, selective “shopping” helps lower the cost of your medical care because you often can choose to receive the same service at a lower price. To compare health care pricing in your area, visit **www.healthcarebluebook.com**. Other resources for shopping around for health care prices can be found at **www.chministries.org/providerlist** and **www.healthgrades.com**.
2) ***Follow the steps under “General information” below.***

## Maternity:

1) ***Obtain medical care as soon as you know you’re pregnant.***
2) ***Ask for an prepayment agreement on your clinic/hospital/doctor’s letterhead.*** These charges are often bundled as a one or two-day stay (sometimes called a “Stork Package”) and are significantly less expensive than being admitted to a facility when it’s time to give birth.
3) ***Submit the prepayment agreement and/or bills to the Christian Healthcare Ministries office.*** Early submission speeds the time for bill sharing. Notify the CHM office immediately if your health care provider sets a time limit for reduced charges (seven months is common.) Send items to:
   Christian Healthcare Ministries
   Attn: Needs Processing
   127 Hazelwood Ave.
   Barberton, OH 44203
4) ***Any charge (lab, sonogram, etc.) incurred after the original prepayment agreement/bills are submitted should be sent to the address above as an “add-on” to the initial amount.***

## General information:

a) ***Inform the health care provider—in an emergency, usually a hospital—that you are a self-pay patient and a member of Christian Healthcare Ministries,*** a group that will help with your bills after other forms of assistance have been

*-more-*

exhausted. At all times carry your CHM membership card so providers will understand your situation (remember to tell providers to bill you directly).

b) ***Ask for a bill reduction (discount).*** Asking for a discount is asking for the same consideration that insured patients receive (due to discounted rates negotiated by their insurers). Many providers will extend a discount to you because it usually means they receive faster payment. Discounts represent nearly 60 percent of all medical bills submitted to CHM, so please don't be shy about asking. Also, any discount (on an eligible medical bill) you help obtain will apply toward your personal responsibility amount (Gold: $500; Silver: $1,000; Bronze: $5,000).

c) ***Whenever possible, contact the CHM Member Advocate department before accepting a discount or making a payment.*** If you have difficulty obtaining a significant discount, our staff can help negotiate with your health care provider(s) to make sure you get the best possible price for your medical care. Remember that if you pay the bill up-front, negotiations cease. Please don't make full payment up-front.

d) ***Apply for any financial assistance available.*** Many members are surprised to find that they qualify for financial assistance, which is money set aside for the express purpose of helping patients. Ask to speak to a financial counselor or decision-maker and complete any forms they give you.

e) ***Ask providers to bill you directly and set up a payment plan with your providers.*** Work with your providers to make whatever monthly payments you can afford until CHM members share your eligible need, at which time their voluntary gifts reimburse your expenditures. Even minimal payments will reassure most providers that the bills will be paid.

f) ***When you receive your itemized bills, send copies of each bill to Christian Healthcare Ministries, along with the completed Needs Processing forms.*** CHM must receive your bills and forms within six months of the date of service. Send the bills immediately—even if a discount is pending—because bills are shared by CHM in the order they are received by our office.

We are all aware that sometimes circumstances far beyond our control take place. **To ensure that each medical need is received, please make copies of each of the items you send to our office.**

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## CHM Needs Processing department

We are pleased to be of service to you in this time of need. If you have any questions or concerns regarding your need, please feel free to contact us at 1-800-791-6225 and ask for the processing representative for your state. If you're calling regarding a maternity need, please let the receptionist know.

# Needs Processing Form

Christian Healthcare Ministries *Galatians 6:2, Acts 2 & 4*

**Return form to:** **Christian Healthcare Ministries** **Attn: Needs Processing** **127 Hazelwood Ave.** **Barberton, OH 44203**
330-848-1511 *phone* 800-791-6225 *toll free*
330-848-4322 *fax*
www.chministries.org

**Instructions: Please read and complete BOTH SIDES of the following form for sharing of your medical bills. (See second page for a list of items to submit in order to expedite sharing of your bills.)**

**MEMBER INFORMATION**

Member number: ______________ Primary member name: ______________

Home phone: (   ) ______________ Work phone: (   ) ______________ Cell phone: (   ) ______________

Valid e-mail address: ______________

Name of member's church: ______________ Church phone: (   ) ______________

Church address: ______________ Church fax: (   ) ______________

**PATIENT INFORMATION**

Patient name: ______________ Date of birth: ____/____/____ Age: ______

**PHYSICIAN'S DIAGNOSIS**

Physician's diagnosis: ______________ Date symptoms began: ____/____/____

***Remember to attach a separate sheet of paper giving a brief explanation of the incident or illness.***

**PREVIOUS CONDITIONS**

Did you have signs, symptoms, or treatment of this condition before joining CHM? ☐ Yes ☐ No

**MATERNITY ONLY**

Expected due date: ____/____/____ Actual date of birth: ____/____/____ Child's name: ______________

**MEDICARE-ELIGIBLE MEMBERS**

Along with the forms in the CHM Needs Processing packet, Medicare-eligible members should submit their Medicare Explanation of Benefits (EOB) form *in lieu of itemized medical bills.*

**ACCIDENTS ONLY**

Accident occurred at: ☐ Home ☐ Other (specify): ______________

If the accident occurred on property other than your own, all bills must be submitted to the responsible party's insurer. Please submit a copy of letter of approval/refusal for payment.

Since Christian Healthcare Ministries members are considered self-pay, we strongly advise that you take advantage of any financial assistance programs that you might be eligible to receive. This information is provided in order to facilitate timely filing for these programs and to lessen the burden of rising medical costs on fellow members. If any other source will pay **all or any part** of your bills for this incident, you must send documentation verifying payments (See Guideline N).

***I understand that CHM members participate out of a desire to share one another's burdens, and it would be an abuse of their trust if I use the money I receive for a shared need for some purpose other than payment of that need. If I have prepaid or made payments, I will consider funds received from CHM as reimbursement. I understand that failure to provide accurate information or failure to use the money for the submitted bills will be a violation of Christian Healthcare Ministries Guidelines.***

***By signing below, I attest that the participating ADULT members included in my membership are Christians living by New Testament principles, attend group worship regularly (health permitting), follow scriptural teaching with regard to alcohol, and do not use tobacco or use drugs illegally. I also attest that all information provided herein is true to the best of my knowledge.***

**Signed** ______________ **Date** ______________

***Continued on back...***

# WORKSHEET AREA

Name: ____________________ Member #: ____________________

**Complete each column of this WORKSHEET AREA. Send the itemized bill for each line completed below along with this form.**

***IMPORTANT! Special instructions:***

***REDUCTION(S):*** *When a bill reduction (discount) is received, your itemized bill should reflect the amount of the reduction.*

***PAID BY OTHER SOURCES:*** *Some examples are Medicare, insurance, Workers' Compensation, etc.*

| | DATE *of service* | PROVIDER *doctor, hospital, pharmacy, etc.* | AMOUNT *of bill* | DISCOUNT AMOUNT | PAID *by you* | PAID *by other source* | BALANCE *due* |
|---|---|---|---|---|---|---|---|
| 1. | | | $ | $ | $ | $ | $ |
| 2. | | | $ | $ | $ | $ | $ |
| 3. | | | $ | $ | $ | $ | $ |
| 4. | | | $ | $ | $ | $ | $ |
| 5. | | | $ | $ | $ | $ | $ |
| 6. | | | $ | $ | $ | $ | $ |
| 7. | | | $ | $ | $ | $ | $ |
| 8. | | | $ | $ | $ | $ | $ |
| 9. | | | $ | $ | $ | $ | $ |
| 10. | | | $ | $ | $ | $ | $ |
| 11. | | | $ | $ | $ | $ | $ |
| 12. | | | $ | $ | $ | $ | $ |
| | | **TOTALS:** | $ | $ | $ | $ | $ |

**Checklist before mailing:**

- ❑ **1.** This signed and completed Needs Processing Form (both sides)
- ❑ **2.** An itemized bill for **each** item listed above with documentation of payments and/or adjustments (discounts). CHM can also accept standardized health care provider billing forms such as CMS-1450, UB-04 or CMS-1500.
- ❑ **3.** Signed and completed Medical Release Information (HIPAA-compliant) Form
- ❑ **4.** A letter explaining the circumstances of this incident
- ❑ **5.** Completed Prayer Page Request Form (**only** if you are submitting bills for a pre-existing condition)

***Failure to submit any of the above items will delay the processing and sharing of your bill(s).***

# Medical Release Information (HIPAA-compliant) Form

Christian Healthcare Ministries *Galatians 6:2, Acts 2 & 4*


**Return form to:** **Christian Healthcare Ministries**
**Attn: Needs Processing**
**127 Hazelwood Ave.**
**Barberton, OH 44203**
*330-848-1511 phone* *800-791-6225 toll free*
*330-848-4322 fax*
*www.chministries.org*


***SECTION A: (PLEASE PRINT)***

| | |
|---|---|
| ***Name:*** ______________________ | ***Address:*** |
| ***Date of birth:*** ______________________ | |
| ***SSN:*** __________ ***CHM #:*** __________ | ***Phone #:*** ______________________ |

I understand that Christian Healthcare Ministries is a not-for-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 and all health information related to my records described in this authorization with the above health care providers, health care facilities, health plans or any other agency involved in my health care or payment for health care.

***SECTION B:***

Description of information being disclosed:

- ☐ Complete Health Record
- ☐ History and Physical Exam
- ☐ Abstract/Pertinent Information
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Emergency Department Record
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ Radiology Reports
- ☐ All records regarding all bills, billing codes, diagnosis codes, and other billing information

***SECTION C:*** ***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.
- This authorization is voluntary and that I may revoke the authorization in writing addressed to *Privacy Officer* at *127 Hazelwood Ave, Barberton, Ohio 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 Individual or Authorized Representative | Print Name of Individual |
| Representative's legal authority to individual | Print Name of Authorized Representative |

Today's Date:

***IMPORTANT: We must have this completed form to present to health care providers before they can legally discuss with us discounts on any of your medical bills. If providers cannot discuss your bills with us due to your refusal to complete this form, your medical bills cannot be shared.***

-- PROVIDE COPY TO MEMBER & COPY TO FILE --

This form is certified HIPAA compliant.

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**BRIEF LETTER EXPLAINING THE CIRCUMSTANCES OF YOUR INCIDENT**
(Maternity needs: No letter is necessary unless you have experienced complications. **All other conditions: This letter is a requirement to process your medical bills for sharing. Failure to submit it will result in a delay in sharing your bills.)**

Name: ______________________ Member #: ______________________

# Prayer Page Request Form

Christian Healthcare Ministries *Galatians 6:2, Acts 2 & 4*


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**Attn: Needs Processing**
**127 Hazelwood Ave.**
**Barberton, OH 44203**
330-848-1511 *phone* 800-791-6225 *toll free*
330-848-4322 *fax*
www.chministries.org


**Instructions: Please complete this form only if you are submitting bills for a pre-existing condition.**

❏ YES, I would like my bill(s) to be considered for listing on the Prayer Page. To the best of my knowledge, I attest that my bills meet the criteria set forth below for Prayer Page sharing eligibility.

Patient name: ______________________________ Member #: ______________
(please print)

Signed: ______________________________ Date: ______________

Amount you are requesting to list on the Prayer Page: $______________________

Address to be printed on the Prayer Page (please print):

______________________________________________________________

How would you like your Prayer Page listing worded? *(Listings may be edited for length or grammar.)*

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

*Upon determination that your bill(s) are eligible for listing on the Prayer Page, our staff will notify you by sending you a welcome packet to guide you through the process of listing your need. At that time, you will be notified when your need will appear on the Prayer Page.*

## What is the Prayer Page?

The Prayer Page appears monthly in the CHM newsletter. The Prayer Page is an additional means by which CHM members help other Christians. It lists members' names, mailing addresses, and information about their medical bills so that other readers can be informed of their needs and step forward to help them through voluntary giving (above and beyond regular monthly financial gifts to CHM).

**To be eligible for the Prayer Page, medical bills must meet the following criteria*:**

- Bills must be from treatment of pre-existing conditions and treatment must follow all other CHM Guidelines for sharing eligibility, including Guidelines regarding your participation level (Gold, Silver, or Bronze).
- Bills must have been incurred after you joined Christian Healthcare Ministries. Bills incurred prior to joining are not eligible for listing on the Prayer Page.
- Medical bills cannot be shared if, at the time you join CHM, the bills are for pre-existing conditions that are actively undergoing treatment other than with maintenance (routine) medications. After the incident is over and your doctor states that you are on a maintenance treatment regimen, bills for any new incident related to the pre-existing illness are eligible for sharing either through the regular CHM program (Gold members only) or through the Prayer Page (Gold, Silver, and Bronze members).
- If you join CHM while pregnant, bills for that pregnancy are not eligible for sharing through the Prayer Page.

**For complete information about pre-existing conditions, please see Guidelines Z and AA.*