



Medical Expense Sharing Request Form

To be completed by member and submitted with every request for sharing

A. HealthShare Account Information

Name _____

Member ID# _____

B. Patient Information

Patient Name _____

Date of Birth _____

C. Reason for Visit:

D. Payment for services

I paid my provider at time of service \$ _____

Provider is billing United Refuah directly

E. General Information

First Date (Onset) of Symptoms _____

Type of Visit: Office Urgent Care Emergency Room

Inpatient Hospitalization Other _____

Is this a wellness visit (physical) or for a medical issue?

Wellness / physical Medical Issue

If a wellness visit / physical, please proceed to Section E.

F. Other Information

Other Health Insurance (including Medicare/Medicaid/Tricare)

Policy # _____

Name of Policy Holder _____

Vehicle Related Accident? YES NO

Work-Related Incident or Illness? YES NO

Is this an Injury-Related illness? YES NO

If Yes, please explain _____

G. IF YOUR PROVIDER CANNOT PROVIDE YOU WITH A CMS-1500 OR SUPERBILL FORM, PLEASE REQUEST THAT THEY COMPLETE THE TABLE BELOW:

Physician Name _____ NPI # _____ Tax ID Number _____

Complete Address _____

If Applicable, (for Providers in Group Practices): Group Name _____ Group NPI # _____

<u>Date</u>	<u>Brief Description</u>	<u>Diagnosis/ ICD Code</u>	<u>CPT Code</u>	<u>Modifier</u>	<u>Amount Charged</u>	<u>Paid by Member</u>

COMPLETED FORMS AND SUPPORTING DOCUMENTATION MAY BE SUBMITTED ONLINE AT WWW.URHS.US,

FAXED TO: (440) 510-0444, EMAILED TO: ADVISORY@UNITEDREFUAHHS.ORG,

OR MAILED TO: URHS, PO BOX 470218, BROADVIEW HEIGHTS, OH 44114

Please include a receipt and a detailed, printed page of all medical costs incurred, including diagnoses, dates, etc.