

Medical Expense Sharing Request Form

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



IF YOUR PROVIDER CANNOT PROVIDE YOU WITH A CMS-1500 OR SUPERBILL FORM, PLEASE REQUEST THAT THEY COMPLETE PROVIDER DETAILS AND TABLE BELOW. THE REMAINDER OF THE FORM SHOULD BE COMPLETED BY THE MEMBER

Physician Name _____ NPI # _____ Tax ID Number _____

Complete Address _____

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

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

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

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 _____

COMPLETED FORMS AND SUPPORTING DOCUMENTATION MAY BE SUBMITTED ONLINE AT WWW.URHS.US,
FAXED TO: (440) 510-0444, EMAILED TO: CLAIMS@UNITEDREFUAHHS.ORG,
OR MAILED TO: URHS, PO BOX 18523, CLEVELAND HEIGHTS, OH 44118

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