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

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_____

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.