Impact Health Sharing

MEDICAL EXPENSE FORM

For Reimbursement and/or Documentation of Out of Pocket Expenses for PRA Accrual

This form should be completed if a member has paid out of pocket for medical treatment or procedure, or prescriptions and is requesting reimbursement as these expenses may be eligible for sharing.

Bills missing any of the requested information below may be returned to you.

PERSONAL INFORMATION (please print clearly)

PRIMARY CONTACT		Membership ID
Address		
City	State	Zip + 4
Home Phone	Member/Patient name that incurred Expenses	

PROVIDER INFORMATION (one form must be submitted for each)

PROVIDER NAME		**PROVIDER TAX ID NUMBER**
Address		
City	State	Zip + 4
Facility Name	Doctor Name	

Description of Charge (Medical appointment, prescription drug, etc.)	Diagnosis Codes (ICD9/ ICD10 Codes)	Procedure Codes (CPT Codes)	Date of Service (MM/DD/YYYY)		Amount Charged	Provider Discount	Amount Paid by Member	Bill or proof of payment attached
			From	To				
								☐
								☐
								☐
								☐
								☐
								☐
			TOTAL CHARGED			**TOTAL FOR CONSIDERATION**		

SIGNATURE	Date

When you are submitting expenses for more than one family member, please use a separate form for each person.

It is suggested that you make copies for your own use before you submit original bills.

BILLS MISSING ANY OF THIS INFORMATION MAY BE RETURNED TO YOU

Your provider should submit associated bills on one of the following forms: CMS 1500, UB or HCFA form. This documentation is necessary in order for the expenses to be considered for sharing.

Check that each document is legible and contains ALL of the following information:

- ✓ Doctor's name
- ✓ Facility name and address
- ✓ Tax ID number
- ✓ Diagnosis codes (Icd9/Icd10 codes)
- ✓ Procedure codes (CPT codes)
- ✓ Full breakdown of charges by service
- ✓ Receipt showing payment
- ✓ Include any discounts given by provider

Prescription charges may be eligible if related to an eligible medical event. Please consult your Guidelines for details. Attach the personalized prescription information (usually a printout attached to the prescription bag) along with your receipt of payment. If unavailable, you can request a duplicate to be printed by your Pharmacist.

The personalized prescription information must include:

- ✓ Patient name
- ✓ Doctor's name
- ✓ Date Rx is filled
- ✓ Rx name
- ✓ Dosage
- ✓ Amount
- ✓ Days supply
- ✓ Pharmacy name and address
- ✓ Total charge
- ✓ Receipt

Please mail this completed form along with the requested documents/receipts to:

Impact Health Sharing | PO Box 3139, Farmington Hills, MI 48333 | (855) 378-6777 | Fax (954) 678-6970