Medi-Share® Medical Bill Submission Form

Complete one form per family member to submit a bill for an eligible medical expense per the **Medi-Share Guidelines** when a provider refuses to bill Medi-Share directly. Bills should not be submitted for ineligible services or conditions (**GL VI:J**), bills that have already been applied to your Annual Household Portion (AHP), or for Provider Fees.

Instructions

Do not complete for ineligible needs (**GL VI:J**) or bills that have already been applied to your Annual Household Portion (AHP).

Ineligible Needs Include (but are not limited to):

- Chiropractic Care (not previously approved)
- Dental Services not related to an accident
- Vision Services
- Mental Health evaluation and treatment not related to an eligible medical
- Services provided by functional medicine, integrative medicine, or regenerative medicine providers

Bills must be received within 1 year from the Date of Service. All eligible submissions will be applied towards any unmet AHP and then shared as outlined per the **Medi-Share Guidelines**.

1. Request that your provider submit directly to Medi-Share using the EDI number (59355) on the back of your member card. ***If your provider will not submit electronically, proceed to the next bullet.***

2. In order to expedite processing times, submit forms labelled as CMS 1500/HCFA - Health Insurance Claim Form or UB-04. These are standard forms which include all necessary information. Examples are on the following page. If submitting one of these forms, skip to step 4.

   PLEASE NOTE: If your provider is listed as in-network in Medi-Share's Provider Search , they are required to either submit directly to Medi-Share or provide a CMS1500/HCFA or UB-04.

3. If unable to obtain a CMS 1500/HCFA or UB-04, the next page outlines all the information that is required in order for a medical bill to be processed. Any missing information will cause the bill to be ineligible for sharing. The missing information will be noted on the EOS(s) for your bill(s).

4. Submit the completed form along with all bills and required information (**GL I-A**) using one of the following methods:
   - Mail: Christian Care Ministry, PO Box 120040, West Melbourne, FL 32912
   - Fax: 321-722-5138
   - Email: memberservices@MyChristianCare.org All email submissions must be sent as a .PDF or .JPG

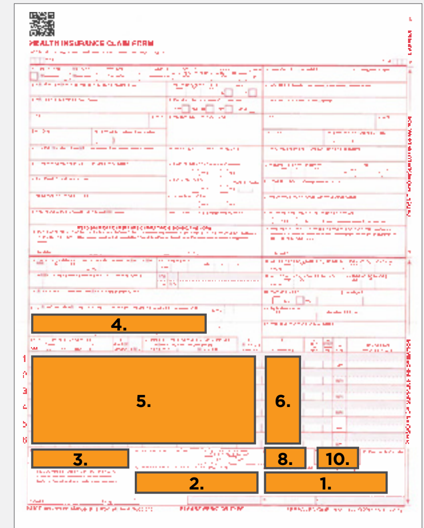
5. Sharing will be limited to the applicable Medicare rates or usual and customary, minus Out of Network penalties, Provider Fees, Discounts and any remaining AHP or Co-Share for the applicable household.

Medi-Share® Medical Bill Submission Form

Bill from the Doctor Must Include the Following

1. Doctors Name
2. Provider's Billing Address
3. Tax ID Number (ex: XX-XXXXXXX)
4. ICD10 Diagnosis Codes (ex: W61.62XD, R53.81)
5. Procedure Codes (ex: 99213, J0131)
6. Any Applicable Modifiers (ex: 25, QK, AA)
7. Full Break Down of Charges by Service
8. Anesthesia Minutes (if Applicable)
9. Total Charged
10. Total Discounts
11. Total Paid
12. Receipt Showing Payment

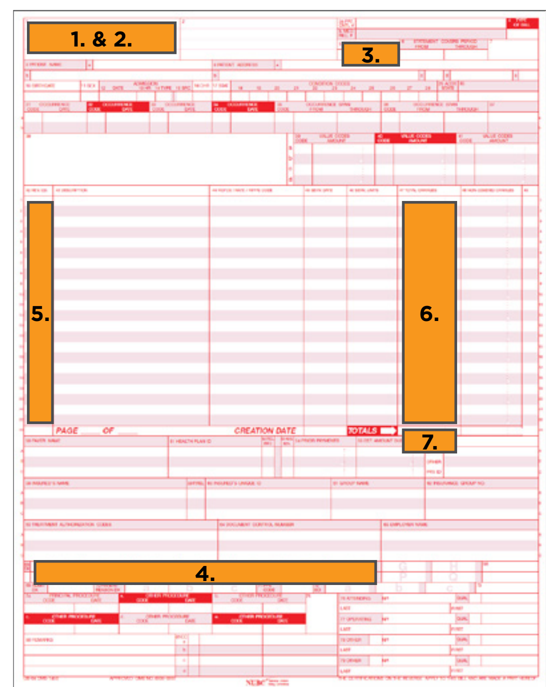
CMS1500/HCFA (Example)



Bill from the Facility Must Include the Following

1. Facility Name
2. Facility Billing Address
3. Tax ID Number (ex: XX-XXXXXXX)
4. Icd10 Diagnosis Codes (ex: W61.62XD, R53.81)
5. Revenue Codes- Facility Services Only (ex: 360, 409)
6. Full Break Down of Charges by Service
7. Total Charged
8. Total Discounts
9. Total Paid
10. Receipt Showing Payment

UB04 (example)



Medi-Share

Medical Bill Submission Form

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Personal Information *(please print clearly)*

HEAD OF HOUSEHOLD	HOUSEHOLD ID NUMBER
ADDRESS	
CITY	STATE	ZIP+4
HOME PHONE	MEMBER/PATIENT NAME THAT INCURRED EXPENSES

Provider Information *(one form must be submitted for each)*

PROVIDER NAME

Description of Charge (Medical appointment, labs, x-rays, etc.)	Date of Service (MM/DD/ YYYY)	Total Billed Amount	Total Discount	Check Box if Member Paid	Total Paid to Provider	Check Once You Have Verified All Required Information is Included
				☐		☐
				☐		☐
				☐		☐
				☐		☐
				☐		☐
				☐		☐
				☐		☐
				☐		☐
				☐		☐

Please email this completed form along with the requested documents/receipts to memberservices@mychristiancare.org, fax to **321-722-5138**, OR mail to: **Christian Care Ministry, PO Box 120040, West Melbourne, FL 32912**