



Please send only one NNF per incident. Use this form to begin the processing of the bills for your medical event. Only one NNF is needed per medical event. Providers should be directed to send their bills directly to the processing center on form UB-04 for hospitals or CMS 1500 for other providers. For patients 65 years of age or older, the Medicare Explanation of Benefits must be attached to each bill.

✓ Please fill out this form completely; an incomplete form may delay sharing

You should only fill out this form for a new medical event, there is no need to submit for a subsequent visit related to the same medical event. However, you may want to submit this medical bill for sharing solely for the purpose of obtaining a discount. In that case, please complete this form, answering yes to the question below, but be aware if the bill is not eligible for sharing, it will not be applied to your AHP or IMR.

Are you submitting this form only for the purpose of a possible discount? YES NO
If you need assistance, call Member Services at (800) 264-2562.

SECTION 1

Household Number on card _____ SSN _____ Effective Date on card ___ / ___ / ___
 Head of Household Name (First) _____ (Last) _____
 Home Phone _____ Work Phone _____
 Cell Phone _____ Email Address _____
 Mailing Address: Street Address _____
 City _____ State _____ Zip _____ - _____ (+4 for PO Boxes)
 Patient Name (First) _____ (Last) _____ DOB ___ / ___ / ___
mm dd yyyy
 Relationship to Head of Household Self Spouse Daughter Son Marital Status of Patient Married Single Widowed Divorced

SECTION 2

- Is the patient an adult child living away from the home of the Head of Household? YES NO If yes, please describe the circumstances:

- Is there insurance or any other resource available to pay all or part of the bills; e.g., workers' compensation, property owner's liability insurance, health insurance, foundations, service organizations, or governmental programs? YES NO
If yes, list the insurance and/or other resource name(s):

SECTION 3

- Name of Primary Physician _____ Physician's Phone _____
 If a Specialist Internist Pediatrician OBGYN Cardiologist Oncologist Gastroenterologist Dermatologist Psychiatrist
 Naturopath Chiropractic Other _____ Are they a PHCS network provider? YES NO
- Name of Specialist _____ Specialist's Phone _____
 Type of Specialist Internist Pediatrician OBGYN Cardiologist Oncologist Gastroenterologist Dermatologist Psychiatrist
 Naturopath Chiropractic Other _____ Are they a PHCS network provider? YES NO
- Hospital Name _____ Hospital's Phone _____
 Are they a PHCS network provider? YES NO DON'T KNOW **Penalties may apply if you choose to utilize a non-PHCS provider.**

SECTION 4

Remember: Payment up front is not required. Please use the Reimbursement form found online at www.MyChristianCare.org to document any out of pocket expenses (not your provider fee). Initial Member Responsibilities and Annual Household Portions are applied at the time the bill is processed, not the date of service.

- Have you paid any amount to providers for this medical event? YES NO
 If yes, then please provide Date of Service, Provider Name, Provider Phone Number, and Amount Paid: _____

SECTION 5

• When the patient's records are reviewed, will there be indication of symptoms, diagnosis, treatment or medication for this condition or a related condition prior to the patient's current membership? YES NO List the month and year of the first symptoms of this condition: ____ / ____
mm yy

For an illness

• Please check all that apply to this need: Surgery Referral to Specialist Hospitalization Medical Procedure or Testing Office Visit

• Please describe current illness, dates of any planned procedures, treatments and/or follow up: _____

• Describe any medical treatment that has already been performed: _____

• List the month and year of the first symptoms of this condition: ____ / ____
mm yy

• If the above is an elective surgical procedure or hospitalization, a pre-eligibility review may be necessary. Please refer to the Medi-Share Guidelines Section VI. H. Medical Procedures Requiring Pre-Eligibility Determination.

After reviewing the above guideline, if you need a pre-eligibility review, please contact Member Services at (800) 264-2562.

For an accident

• Please check all that apply to this need: Surgery Referral to Specialist Hospitalization Medical Procedure or Testing Office Visit

• Date of accident: ____ / ____ / ____ Was an accident report filed? YES NO
mm dd yy

• The accident occurred at: Home Work School Other

Describe if other, describe: _____

• Was a motorized vehicle involved in the accident? YES NO

• Did the accident occur while participating in an organized sports activity? YES NO

• Describe the accident: When, Where and How: _____

• Briefly describe the injuries sustained: _____

• Describe any medical treatment that has already been performed: _____

• Do you anticipate any additional treatment to occur? YES NO If yes, please describe: _____

For maternity

• Expected delivery date: ____ / ____ / ____ Will you be using a midwife? (View Guidelines VII. A.) YES NO
mm dd yy

• Are you planning for a cesarean section? YES NO

SIGNATURE

I certify that I have read and understand the Medi-Share Guidelines Section II. Membership Qualification and that I and the patient continue to qualify for membership in the Medi-Share program under those guidelines. I also certify that I (and the patient if applicable) continue to profess the statement of faith and am living pursuant to the Christian lifestyle requirements outlined in the guidelines (Section II. A. Christian Testimony).

Signature (parent if patient is under 18 years old) _____ Date: ____ / ____ / ____
mm dd yyyy