Expense Sharing Request Form Instruction Guide

What is this form for?
This form is for members who request member sharing of an expense that was paid out-of-pocket.

To ensure faster processing...
If you write on the form, please use black or blue ink and print clearly and legibly. You can also use your computer to complete this form and then print it out and mail or fax to us. Complete all the applicable fields on the form. Ask your provider for the Provider Information or have them fill it out for you.

Be sure to submit a separate form for each expense sharing request.

If you have insurance or Medicare, please include the explanation of benefits (EOB) from your insurance or Medicare.

Ask your provider to give you an Itemized Bill or Invoice that includes all of the following for each date of service.

IMPORTANT: This information must be on the invoice as it is required to process the request for expense sharing. Missing information can result in a delay in processing eligibility to submit your request for member sharing.

Please be sure the information is clear and readable.

- **Patient Name**
- **Diagnosis Codes -** *Request with date of service after October 1, 2016 must be ICD10*
- **Procedure Codes (CPT, HCPC) -** *with any applicable modifiers*
- **Units for each procedure code**
- **The billed amount for each procedure code**
- **Place of service code**

What happens next...
After we process your form and your request has been submitted for member sharing, we will send you an Explanation of Sharing (EOS). The EOS will explain the charges that have been shared by the members, the charges applied to your Individual Sharing Amount, and any other charges that were not shared and thus you continue to owe your health care provider.

Please keep your EOS on file for future reference.

Once you have completed the form, email, fax or mail it to OneShare Health. Be sure to attach the Itemized Bill/Invoice and any receipts of your payments.

This completed form, together with the itemized bills, should be submitted to one of the following:

OneShare Health
PO BOX 825
Uniontown, OH 44685

Fax:
682-651-7397

Email:
sharing@onesharehealth.com

"Carry each other's burdens, and in this way you will fulfill the law of Christ." **Galatians 6:2 (NIV)**

OneShare Health®

Expense Sharing Request Form

SECTION 1.			
First Name:		M.I.:	Last Name:
Mailing Address:			City:
State:	Zip:		Phone Number:

SECTION 2.	
Payor Number: **23223**	Member Number:
Patients Full Name (Last, First, Middle Initial):	
Patient Sex: ☐ Male ☐ Female	Patient Date of Birth:
Patient's Relationship to Primary Member: ☐ Self ☐ Spouse ☐ Child ☐ Adult Dependent ☐ Other	
Explain Other:	

SECTION 3.		
Provider Name:		Provider Tax Identification Number:
NPI Number:		Group/Facility Name:
Provider Address:		City:
State:	Zip:	Phone Number:
Facility where services were performed:		
Facility Name:		
Facility Tax Identification Number:		NPI Number:
Address (the physical address the service was performed):		
City:	State:	Zip:

SECTION 4.		
Type of Treatment Received: Please use a separate expense sharing request form for each different type of treatment. **PLEASE NOTE:** Preventive care includes immunizations, annual well baby care.		
Date of Service:		
Diagnostic Code(s) - (Must be ICD10 Codes):		
Code:	Code:	Code:
Code:	Code:	Code:
Rev Code(s) - (3 digit codes for facility bills):		
Code:	Code:	Code:
Code:	Code:	Code:
Procedure Code(s) - (Must be 5 digit CPT, HCPC codes with any applicable modifiers):		
Code:	Units for procedure:	Billed amount:
Code:	Units for procedure:	Billed amount:
Code:	Units for procedure:	Billed amount:
Code:	Units for procedure:	Billed amount:
Place of Service Code (2 digits for provider bills):		
Code:	Code:	Code:
NDC Code(s) (National Drug Codes related to RX Medication):		
Code:	Code:	Code:
Code:	Code:	Code:

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SECTION 5.
DESCRIBE: Diagnosis, symptoms of illness, or explain preventive or routine care received.

***Manual bills are subject to delays and/or rejection if information is missing from the above sections.**

SECTION 6.	
Was Illness or Injury Work Related? ☐ Yes ☐ No	If Injury, Was a Motor Vehicle Involved? ☐ Yes ☐ No
Name of Employer:	Address of Employer:

SECTION 7.		
Is Patient Covered Under Any Health Benefits Plan (Besides Medicaid, Medicare, or Champus)? ☐ Yes ☐ No		
Insurance Co:		Address:
Employer:		Name:
Policy #:		Effective Date of Coverage:
Sex of Insured: ☐ Male ☐ Female	Date of Birth:	Relationship to Patient:

SECTION 8.
☐ **Assignment of Sharing:** Check this box if you would like OneShare to pay expenses shared by members directly to the doctor/provider.
By signing below, I am stating that all information herein is correct. Any person who knowingly files an expense sharing request containing any misrepresentation or any false, incomplete, or misleading information, may be subject to removal from membership and to applicable legal action.
Signature: _____ **Date:** _____

OneShare Health, LLC is not an insurance company but a religious health care sharing ministry. For our full disclosures, see www.onesharehealth.com/legal-notices for the most up to date state availability listing.